

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04654

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Foxleigh Nursing Home</b>		d. STREET ADDRESS <b>130 Slade Ave., Apt. 113</b>	
3. NAME OF DECEASED (Type or print) First <b>Abraham</b> Middle <b>Abrams</b> Last <b>Abrams</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1886</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isser Abrams</b>		14. MOTHER'S MAIDEN NAME <b>Leah ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-2357</b>	
17. INFORMANT <b>Mrs. Rose Abrams, 130 Slade Ave., Apt. 113</b>		Address <b>Balto., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerotic Hypertensive C-V Disease</b> (b) <b>Uremia</b> DUE TO <b>Chr. Nephrosclerosis</b> (c) <b>Fractured hip-pinned; Chr. Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks. est.</b> <b>10 yrs.</b> <b>1 mo. est.</b> <b>10 yrs. est.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured hip-pinned; Chr. Emphysema</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped in bathtub &amp; fractured hip(right)</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7 AM</b> <b>3-15</b> <b>1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore</b> <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		22. DATE SIGNED <b>4-5-67</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		Address (Street or P.O. Box) <b>6 Hanover Rd., Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beth Tfiloh</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b> <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reist. Rd.</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04655

CERTIFICATE OF DEATH

04655

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>		c. LENGTH OF STAY IN TB <b>1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>5724 ROCK SPRING ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>LEONARD</b> Middle <b>--</b> Last <b>ADELHARDT</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 24, 1893</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN ADELHARDT</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE KEMPER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>213 10 99 90</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE INTRA ABDOMINAL HEMORRHAGE</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>HEMORRHAGIC SARCOMA INVOLVING LIVER, SPLEEN AND SMALL INTESTINE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>4/9/67</b> , 19 to <b>4/10/67</b> , 19, that (x) (we) last saw the deceased alive on <b>4/10/67</b> , 19, and that death occurred at <b>2:15P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>4/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>LORING BYERS FUNERAL CHAPEL</b>		25. REC'D BY REGISTRAR <b>RANDALLSTOWN, MARYLAND</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>APR 13 1967</b>	

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO: SAC, ALBUQUERQUE (100-100000)  
FROM: SAC, DENVER (100-100000) (P)  
SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or letter body.]

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04656.

CERTIFICATE OF DEATH

04656

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>P. &amp; COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>ABOUT 18 months</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLSIDE md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>L.</b> Last <b>ALLISON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1878</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WASHINGTON HARMON</b>		14. MOTHER'S MAIDEN NAME <b>SUSANNA DUSTIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-03-4463</b>	
17. INFORMANT <b>SPRING GROVE STATE HOSP CATONSVILLE MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1193 X</b> (b) <b>PARKINSONISM</b> (c) <b>GENERALIZED ARTERIO SCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-11-1965</b> , to <b>4-15-1967</b> , that (I) (we) last saw the deceased alive on <b>4-15-1967</b> , and that death occurred at <b>7-15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>NARCISO W. CARMONA M.D.</b>		22b. DATE SIGNED <b>4/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NARCISO W. CARMONA</b>		22d. ADDRESS <b>Spring Grove S. Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APR. 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SLATE RIDGE</b>	23d. LOCATION (City or Town) (County) (State) <b>DELTA, PA.</b>
24. FUNERAL DIRECTOR <b>John H. Harkin, DELTA, PA.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## References

ISSN 0013-788X • 1998/01 • 17(1)

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पु.सं.१४२७/१९९७

21-03-2022 10:00 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04657						04657					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Baltimore</i>			MARYLAND			a. STATE <i>Maryland</i>			b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Halothorpe</i>			03-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Shangri-La</i>						d. STREET ADDRESS <i>4602 Rehbaum Ave.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>John H. Alloway</i>						4. DATE OF DEATH <i>4/26</i>			Month Day Year <i>1967</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/29/05</i>		9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Funeral</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John R. Alloway</i>						14. MOTHER'S MAIDEN NAME <i>Rosa E. Lugenebell</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>213-05-9266</i>		17. INFORMANT Address <i>Louise Alloway 4602 Rehbaum Ave.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic renal cell</i> <i>180X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of the kidney</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>66</i> , to <i>April 26</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>April 25</i> , 19 <i>67</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Herbert J. Lexickas</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/27/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Dr. Herbert Lexickas</i>						22d. ADDRESS <i>1073 Maiden Choice Lane</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/29/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bonden Park Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>					
24. FUNERAL DIRECTOR <i>Embrix Inc. 1328 Sulphur Sp. Ct.</i>						25a. REC'D BY REGISTRAR <i>APR 28 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Gage</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04658

CERTIFICATE OF DEATH

04658

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21221</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		d. STREET ADDRESS <b>801 Norris Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>J</b> Last <b>AMRHEIN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/20/99</b>
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Millwright</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Phillip Amrhein</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Schiefer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-0757</b>	
17. INFORMANT <b>Mrs. Mary M. Amrhein</b>		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of left coronary artery.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>April 13, 1967</b> to <b>April 13, 1967</b> , that (we) lost saw the deceased alive on <b>April 13, 1967</b> , and that death occurred at <b>6:40 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>M.S. Cockburn, M.D.</b>		22b. DATE SIGNED <b>April 14, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE THEREOF <b>4/17/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04659

CERTIFICATE OF DEATH

04659

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. LENGTH OF STAY IN TB <b>8 hrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTO MEDICAL CENTER</b>				e. STREET ADDRESS <b>225 BOSLEY AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>LYMAN</b> Last <b>ANDERSON SR.</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/94</b>	9. AGE (In years last birthday) <b>72</b> yrs	10. UNDER 1 YEAR Months Days Hours M n		11. IF UNDER 24 HRS Hours M n
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEST GUARDMAN - RET.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>A. T. T. CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO., Co., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>FRANK ANDERSON</b>				14. MOTHER'S MAIDEN NAME <b>CECELIA ARMSTRONG</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or series of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO <b>212 03 5032</b>	17. INFORMANT <b>PT'S HISTORY</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>ASCVD</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> , 19 <b>67</b> , to <b>4-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-5</b> , 19 <b>67</b> , and that death occurred at <b>12:30 AM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Mario B Ines</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARIO B INES MD</b>				22d. ADDRESS <b>GBMC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APR. 8, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DRUIDRIDGE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PIKESVILLE, MD.</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

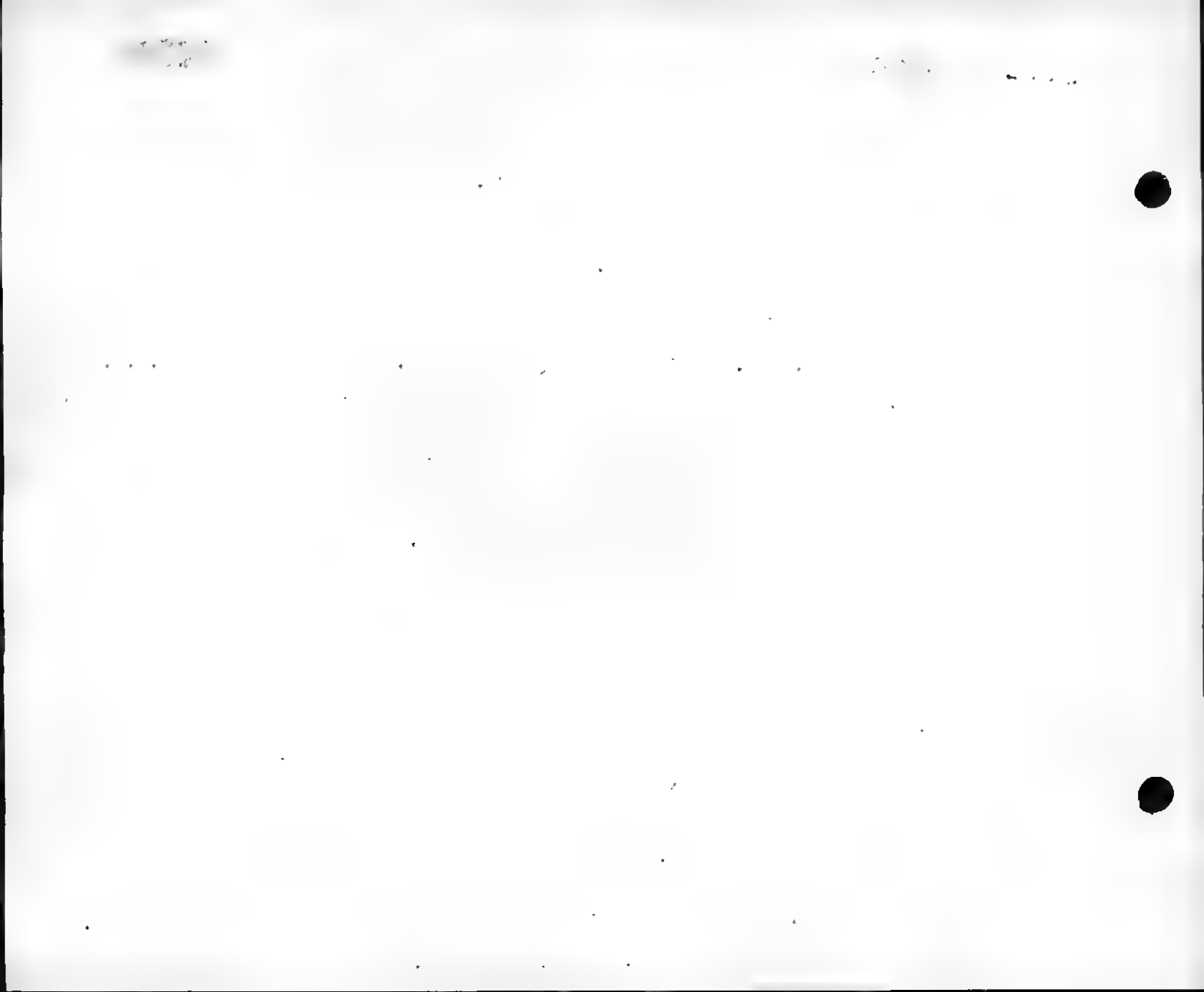
FOR STATE HEALTH DEPT.

04660

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04660

1. PLACE OF DEATH a COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c LENGTH OF STAY in 1b <b>6 days</b>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Randallstown</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hospital</b>				d STREET ADDRESS <b>3612 Briarstone Road</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Orren</b> Middle <b>L.</b> Last <b>Andrews</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/25/1886</b>	9. AGE (in years last birthday) <b>81 yrs</b>	F UNDER 1 YEAR Months <b>2</b> Days <b>15</b>	F UNDER 24 HRS Hours <b>3</b> Min <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Mfg. Rep.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Andrews</b>				14. MOTHER'S MAIDEN NAME <b>Mabel Gessner Rosalia Adell Porter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>363-03-6103 A</b>		17. INFORMANT <b>Hospital Chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>3 days post operative rt.</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) <b>hip prosthesis</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Fell down the basement steps</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:15 a.m. 3/29/ 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Randallstown, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. CAPLES</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED <b>4-3-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, 21208, Md.</b>	
24. FUNERAL DIRECTOR <b>Loring Byers-3728 Liberty Rd. Randallstown, Md.</b>				25a. RECD BY REGISTRAR <b>APR 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate writing the ward pending in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04661

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea 21206</b>				c LENGTH OF STAY IN lb <b>17 years</b>			
d NAME OF HOSP. AL OR INSTITUTION (If not in hospital, give street address) <b>7549 Belair Road</b>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Antczak</b> Last <b>Antczak</b>				4 DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>1967</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>6/13/91</b>	
9 AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b> Hours <b>19</b> Min <b>67</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Minnesota</b>				12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13 FATHER'S NAME <b>August Kobaskie</b>				14 MOTHER'S MAIDEN NAME <b>Elizabeth Sroda</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16 SOCIAL SECURITY NO <b>213-48-6424</b>		17 INFORMANT (Daughter) <b>Mrs. Christina Borys, 7551 Belair Rd.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4401</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home form factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Balto. Md.</b> Address (Street, city, town or county) <b>7501 York Rd.</b>			
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/29/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, Inc. 2829 Hudson St. Balto. Md.</b>				25a REC'D BY REGISTRAR DATE <b>APR 27 1967</b>		25b REGISTRAR'S SIGNATURE <b>W. C. E. Judge</b>	

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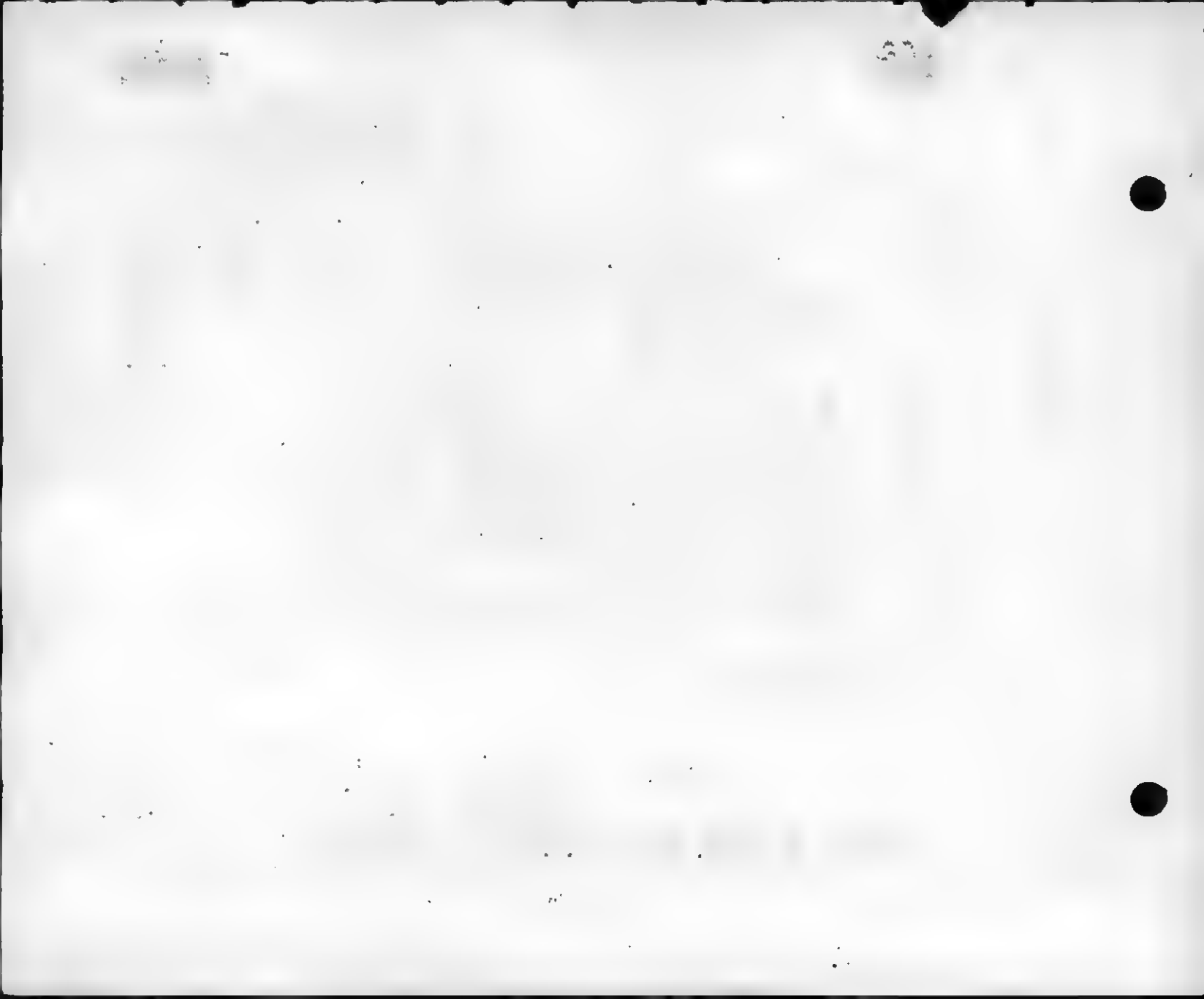


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>04662</b> 1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN ID <b>1yr5mth2dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>						<b>04662</b> 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b> d. STREET ADDRESS <b>1915 Fox St. - Apt. 202</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>M.</b> Last <b>Ardinger</b>						4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1967</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1911</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Winfred Dean</b>						14. MOTHER'S MAIDEN NAME <b>Effie Mills</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>11/2X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Pneumonia</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Nov. 8</b> , <b>12:50</b> to <b>April 12, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 12 1967</b> , and that death occurred at <b>P.</b> M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Evelio A. Felipe, M.D.</b>						22b. DATE SIGNED <b>4-12-67</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>Evelio A. Felipe, M.D.</b>						22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL, Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>4/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairfax Memory Gardens</b>			23d. LOCATION (City, town or county) (State) <b>Fairfax Virginia</b>		
24. FUNERAL DIRECTOR <b>Howard H. Hubbard Funeral Home</b>						ADDRESS <b>4107 Wilkens Ave.</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04663

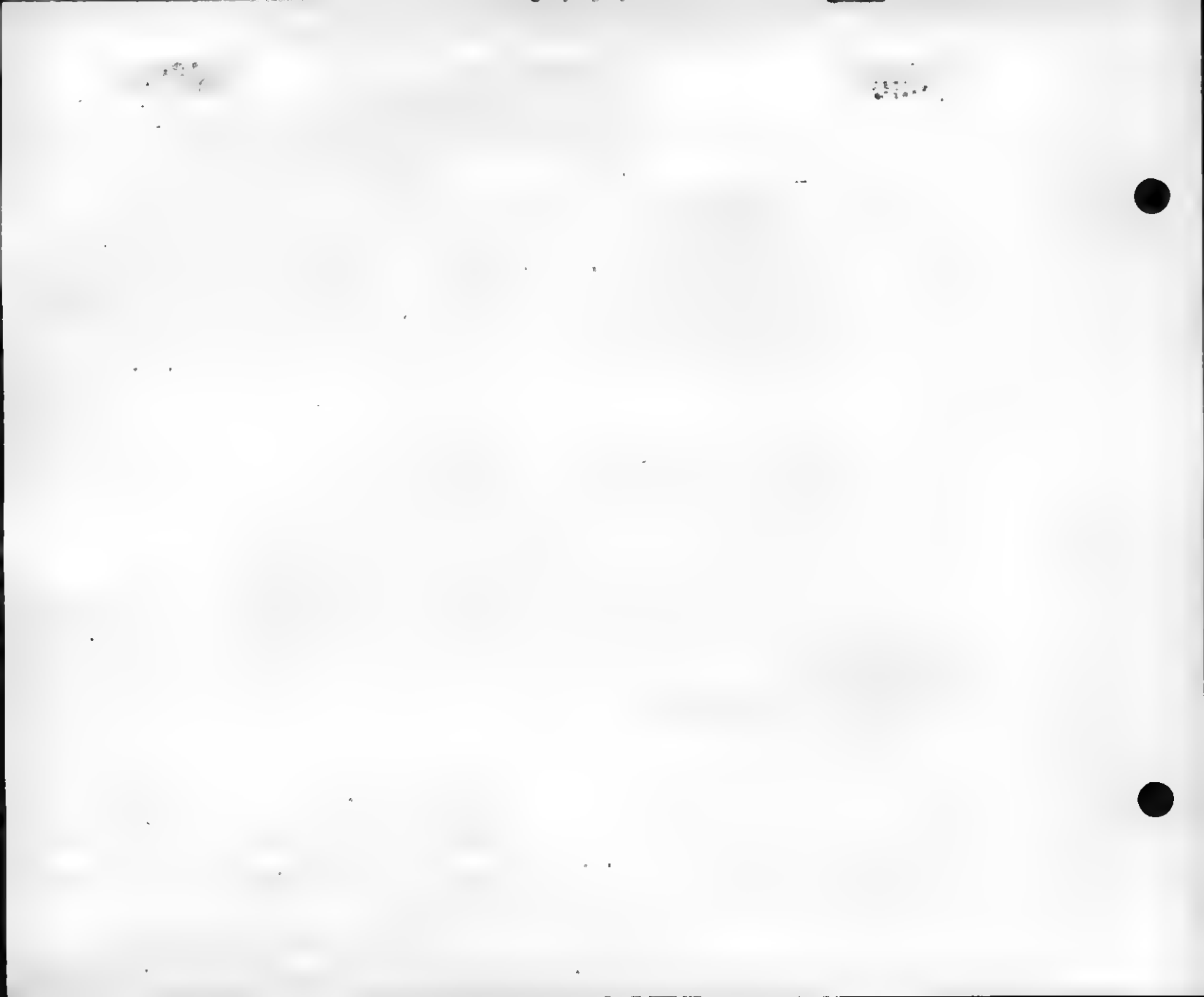
## CERTIFICATE OF DEATH

04663

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>19 days</b>		2. USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>317 Martingale Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>L.</b> Last <b>Armstrong</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1913</b>
9. AGE (In years last birthday) <b>53 yrs</b>		10. IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min <b>_____</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife (cost clerk)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>meat packing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frederick Krasser</b>		14. MOTHER'S MAIDEN NAME <b>Theresa C. Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, unknown) (If yes give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>212-03-7557</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>_____</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>_____</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>_____</b> DUE TO <b>_____</b> (c) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>_____</b> p.m. <b>_____</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <b>_____</b> at work <b>_____</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that <del>Dr</del> (this hospital) attended the deceased from <b>March 30, 19 67</b> to <b>April 9, 19 67</b> , that <del>he</del> (we) last saw the deceased alive on <b>April 9, 19 67</b> , and that death occurred at <b>1:48</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Evelio A. Felipe, M.D.</b>		22b. DATE SIGNED <b>4-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Evelio A. Felipe, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 12, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>STERLING FUNERAL ESTATE 736 Edm. Av. Catonsville, Md.</b>		25. APR 12 1967 DATE	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		27. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04664

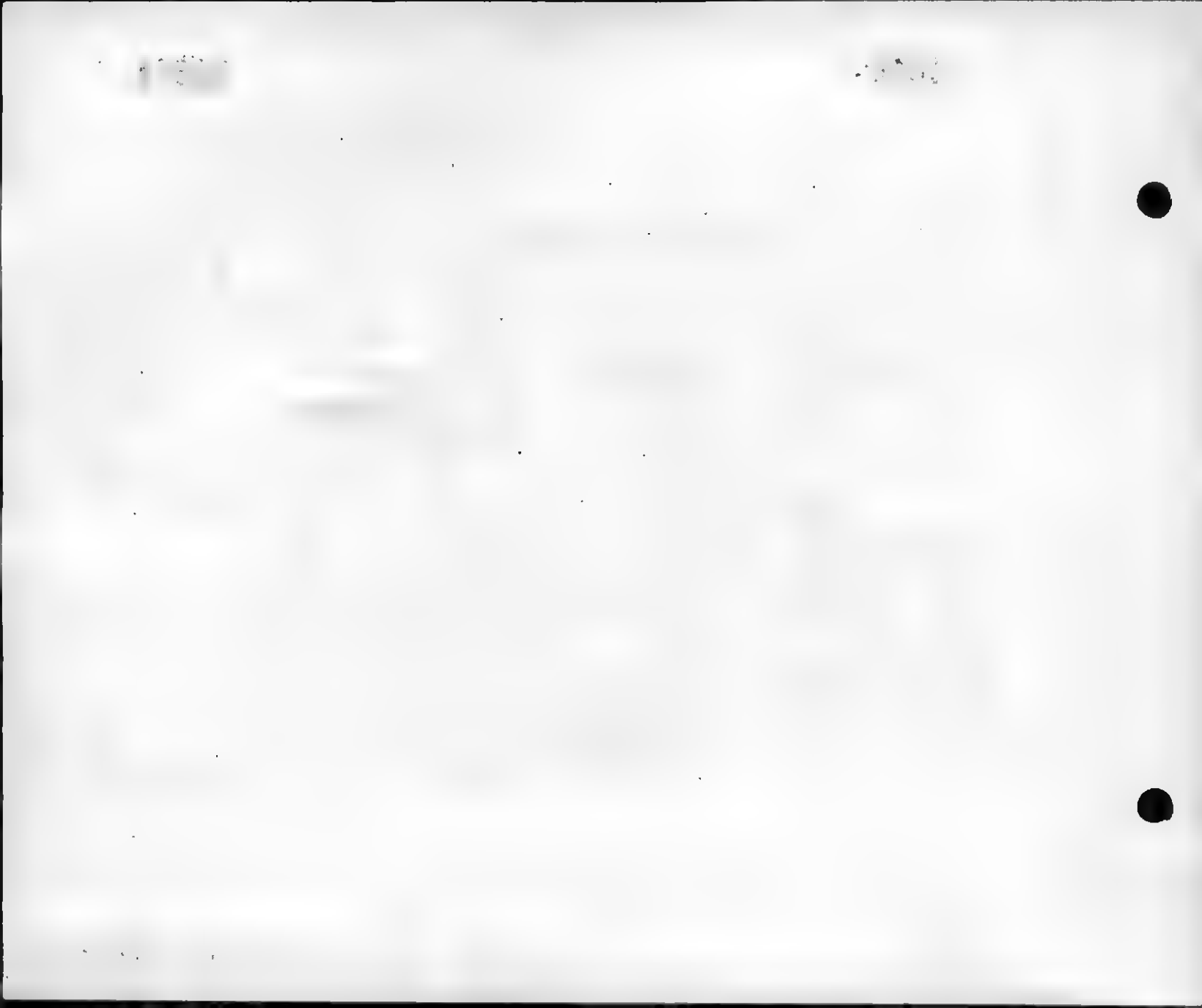
**CERTIFICATE OF DEATH**

04664

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp</u>				d. STREET ADDRESS <u>6509 Windsor Mill Rd.</u>			
3 NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>M</u> Last <u>Arrington</u>				4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 30 - 1969</u>	9 AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Colesium</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Amos Arrington</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE <del>ARRINGTON</del> Carr</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>213-03-381</u>		17 INFORMANT <u>Ernest Arrington</u>			<u>3519 Essex Rd.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion (Probable)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1948</u> to <u>4/29, 1967</u> that (I) (we) last saw the deceased alive on <u>4/29, 1967</u> , and that death occurred at <u>LA</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>C. Mendelis</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/29/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>C. Mendelis</u>				22d. ADDRESS <u>2308 Edmondson Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Memorial Cem</u>		23d. LOCATION (City or town) (County) (State) <u>  </u>	
24 FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hgts Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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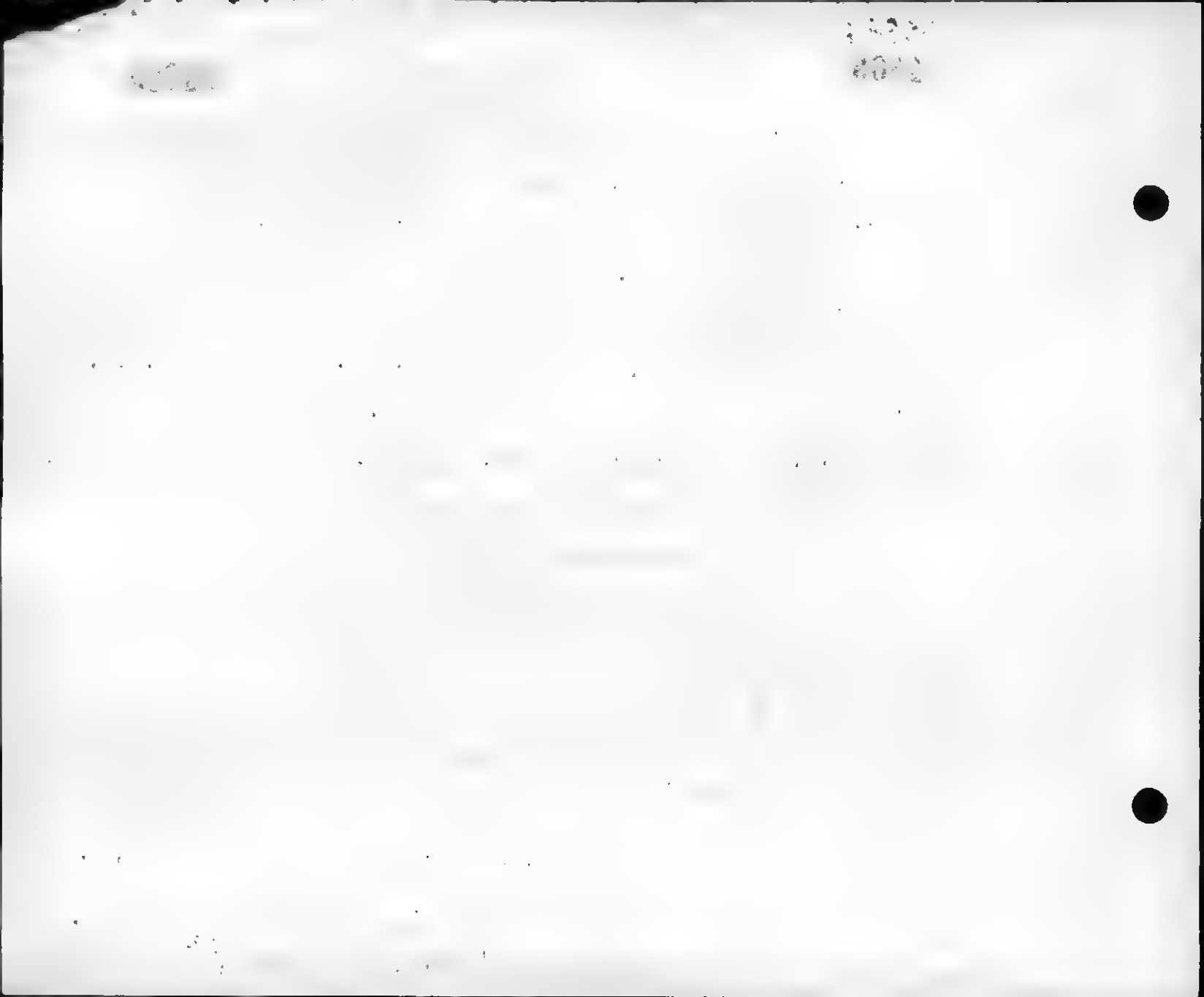
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04665

CERTIFICATE OF DEATH

04665

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1748 Joan Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>C.</b> Last <b>Backus</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-93</b>		9. AGE (In years last birthday) <b>73</b> yrs	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Fire Dept.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Backus</b>				14. MOTHER'S MAIDEN NAME <b>Ella T. Danaher</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO <b>W.W.11 214-24-8277</b>		17. INFORMANT <b>Mrs. Helen V. Langhirt</b> Address <b>1748 Joan Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonitis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Large esophageal diverticulum</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1967</b> , to <b>April 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Antonio Razo</b>				22b. DATE SIGNED <b>April 5, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Antonio Razo</b>	
22d. ADDRESS <b>7620 York Road- Towson</b>				22e. ADDRESS <b>21204, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>				25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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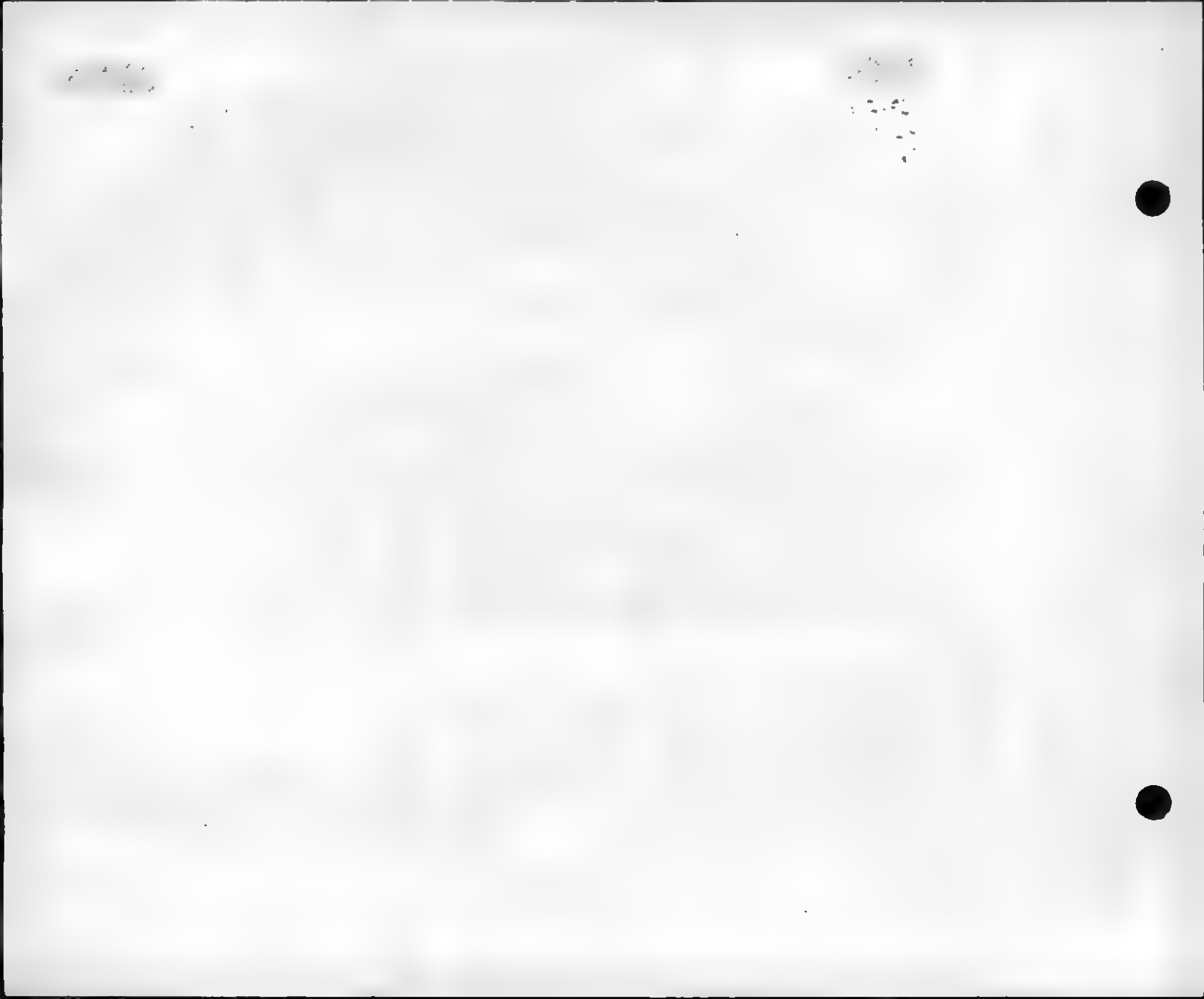
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04666

CERTIFICATE OF DEATH

04666

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>2005 Oak Drive 21207</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JAMES S. BAER</u>				4. DATE OF DEATH Month Day Year <u>Apr 14 1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-08</u>	9. AGE (In years last birthday) <u>59</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SOCIAL SEC.</u>		11 BIRTHPLACE (County & State or foreign country) <u>BALTIMORE</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GUY BAER</u>				14. MOTHER'S MAIDEN NAME <u>STALEY Stehley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-3120</u>		17. INFORMANT Address <u>Ruth Agnes Baer - Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Interval BETWEEN ONSET AND DEATH <u>8</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-11</u> , 19 <u>67</u> , to <u>4-14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>67</u> , and that death occurred at <u>12:50 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>D. Simon, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-14-67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Elsworth Armacost - 4600 Liberty Heights Ave</u>				25a. REC'D BY REGISTRAR DATE <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
04667 Item #2b, c & d Film #0387 4/20/67 pc

<b>PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>110 CUSION Finksburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women's &amp; Men's Home</u>		d. STREET ADDRESS <u>Box 88</u> <u>6147141414141414</u>	
<b>3 NAME OF DECEASED</b> (Type or print) <u>JANE</u> <u>Bell</u> <u>Bailey</u>		<b>4 DATE OF DEATH</b> Month <u>April</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 28 1876</u>
9 AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Jamesville N.C</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ezra H Bailey</u>	
14. MOTHER'S MAIDEN NAME <u>Balham, Mary</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-46-418</u>		17. INFORMANT <u>Aged Women's &amp; Men's Home</u> - <u>Same as #2</u>	
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , to <u>April 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1967</u> , and that death occurred at <u>4:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Newland Edward Day</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY</u>		22b. DATE SIGNED <u>April 10, 1967</u>	
22d. ADDRESS <u>4-E-33rd ST Baltimore Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE THEREOF <u>4-12-67</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>GRAND RIDGE</u>	
23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE BALT. MD</u>		24. FUNERAL DIRECTOR <u>WM. COOK 1300 Ks Towson Towson-Md</u>	
25a. REC'D BY REGISTRAR <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

1862

1862





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

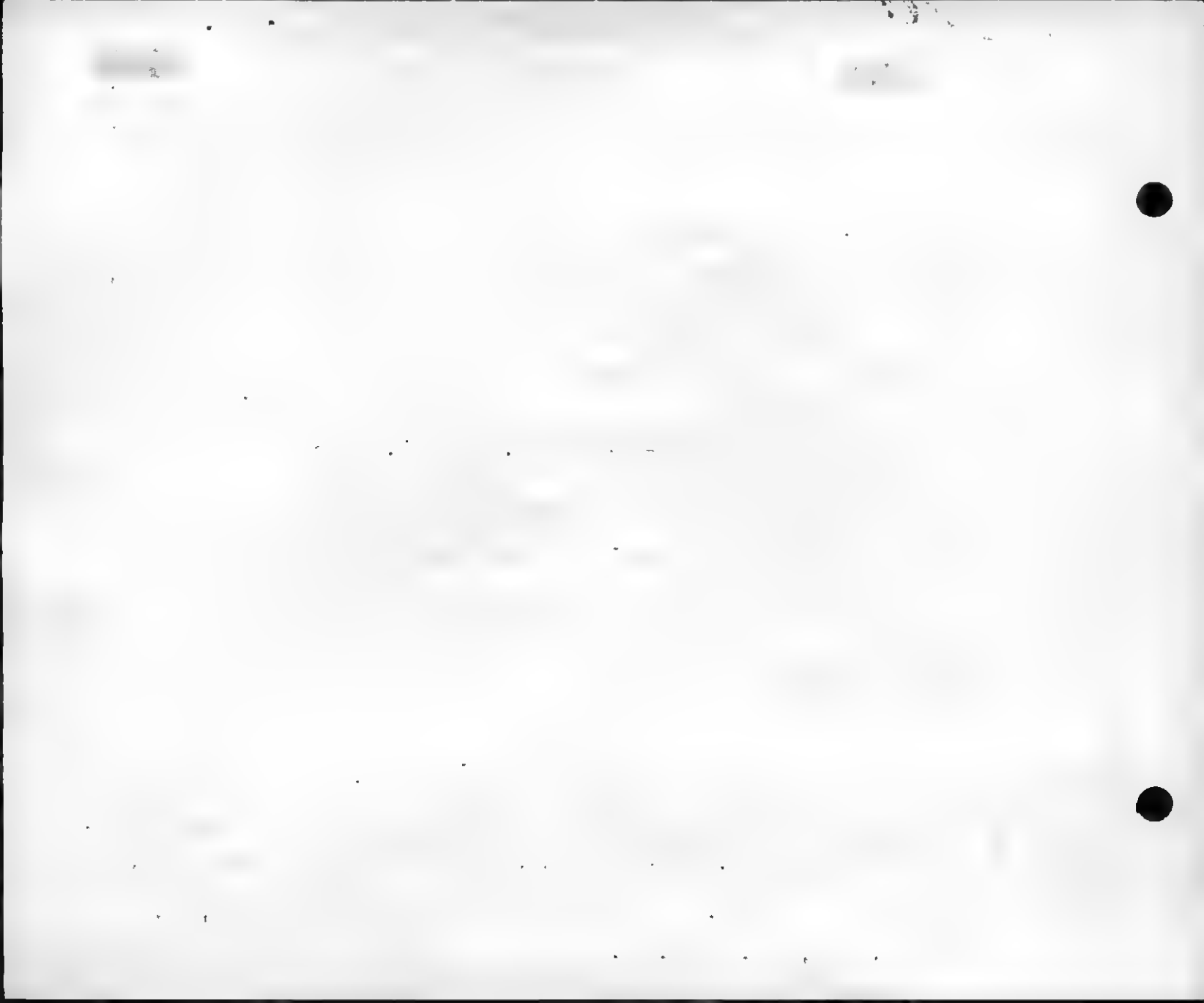
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04668

CERTIFICATE OF DEATH

04668

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN It <b>21234</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		e STREET ADDRESS <b>3518 Hiss Avenue</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Frances Baker</b>		4. DATE OF DEATH Month Day Year <b>April 23, 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4-9-92</b>
9. AGE (n years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eugene Bena</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-3108</b>	
17. INFORMANT <b>Mr. Robert N. Baker</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Thrombosis (left)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure -Class IV</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 21</b> , 19 <b>67</b> , to <b>April 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 23, 1967</b> , and that death occurred at <b>4:20AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Efraim L. Reyes</i>		22b. DATE SIGNED <b>April 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Efraim L. Reyes M.D.</b>		22d. ADDRESS <b>7620 York Road -Towson-21204, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/26/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
ISM 7 63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04669											
04669											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2705 Woodcourt Road</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2705 Woodcourt Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JACOB</b>						4. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>1967</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 1892</b>		9. AGE (in years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BUTCHER</b>				11. BIRTHPLACE (County & State, or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MENDEL</b>				14. MOTHER'S MAIDEN NAME <b>SARAH</b>				Address <b>MINNIE B. HYATT - 2705 Woodcourt Rd</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. co.)				16. SOCIAL SECURITY NO				17. INFORMANT <b>MINNIE B. HYATT - 2705 Woodcourt Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4516</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artemia</b> DUE TO (c) <b>Secondary Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thick Lip 1 year ago</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>April 1966</b> to <b>April 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1967</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above											
22a. SIGNATURE <b>Nathan E. Needle</b> M.D. 22b. DATE SIGNED <b>April 5/67</b> 22c. PHYSICIAN'S NAME (Type) <b>NATHAN E. NEEDLE, M.D.</b> 22d. ADDRESS <b>6506 Oak Heights Dr. Baltimore, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>4/5/1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>ROSEDALE</b> 23d. LOCATION (City, town or county) (State) <b>BALTIMORE MD</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>SYLVAN S. LEWIS &amp; SON, INC.</b> 25a. REC'D BY REGISTRAR <b>APR 5 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>											

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04670**

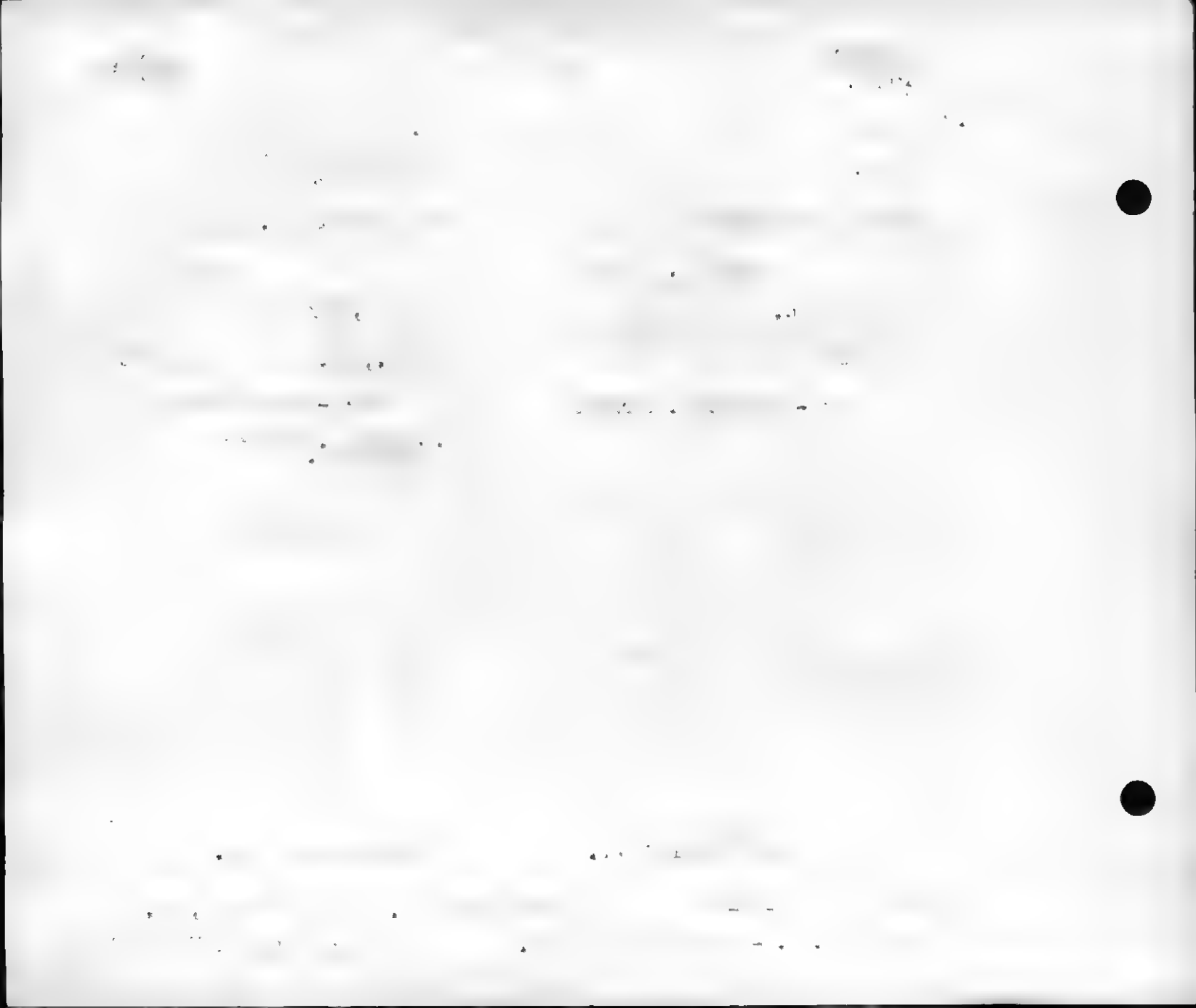
**CERTIFICATE OF DEATH**

**04670**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>		d. STREET ADDRESS <b>306 Roundhill Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rosa S. Bell</b>		4. DATE OF DEATH Month Day Year <b>April 25 19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1883</b>
9. AGE (In years last birthday) yts <b>84</b>		10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Late - William H. Birkett</b>		14. MOTHER'S MAIDEN NAME <b>Late - Willie Mason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mr. Joseph W. Armiger</b> <b>225 Burke Ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4501</b> <b>Crown thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis Cardio Vase</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancer of face</b> <b>Hypochromic anemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/28</b> , 19 <b>62</b> , to <b>4/25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>67</b> , and that death occurred at <b>C.P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Cliff Ratliff, Jr.</b>		22b. DATE SIGNED <b>4/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Cliff Ratliff, Jr.</b>		22d. ADDRESS <b>4605 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO **REGISTRY** **Medical Examiner**: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04671

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) (If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2 FLAGSHIP RD</u>		d. STREET ADDRESS <u>3 EASTSHIP</u>	
3 NAME OF DECEASED (Type or print) First <u>RENA</u> Middle <u>BENDER</u> Last <u>BENDER</u>		4 DATE OF DEATH Month <u>APRIL</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>APR 23, 1888</u>
9 AGE (In years, last birthday) <u>79</u> yrs		10 UNDER 1 YEAR Month <u>7</u> Days <u>29</u> Hours <u>1</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>HENRY BETZ</u>		14 MOTHER'S MAIDEN NAME <u>JULIA PUGH</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>MRS RUTH ROCK - 2 FLAGSHIP</u>	
17 INFORMANT <u>MRS RUTH ROCK - 2 FLAGSHIP</u>		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>A-S-C-V. Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day Year Hour <u>19</u> o.m. p.m.		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f City or town (County) (State)	
21 I certify that I took charge of the remains described above. I held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. DAVIS</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u>DUNDALK MD</u>	
22. DATE SIGNED <u>4/29/67</u>			
23a IF BURIAL OR CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>MAY 1, 1967</u>	23c NAME OF CEMETERY OR REMATORY <u>OAK LAWN</u>	23d LOCATION (City or town) (County) (State) <u>COLETON MD</u>
24 FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>		25 REFERRED BY REGISTRAR <u>MAI 3 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

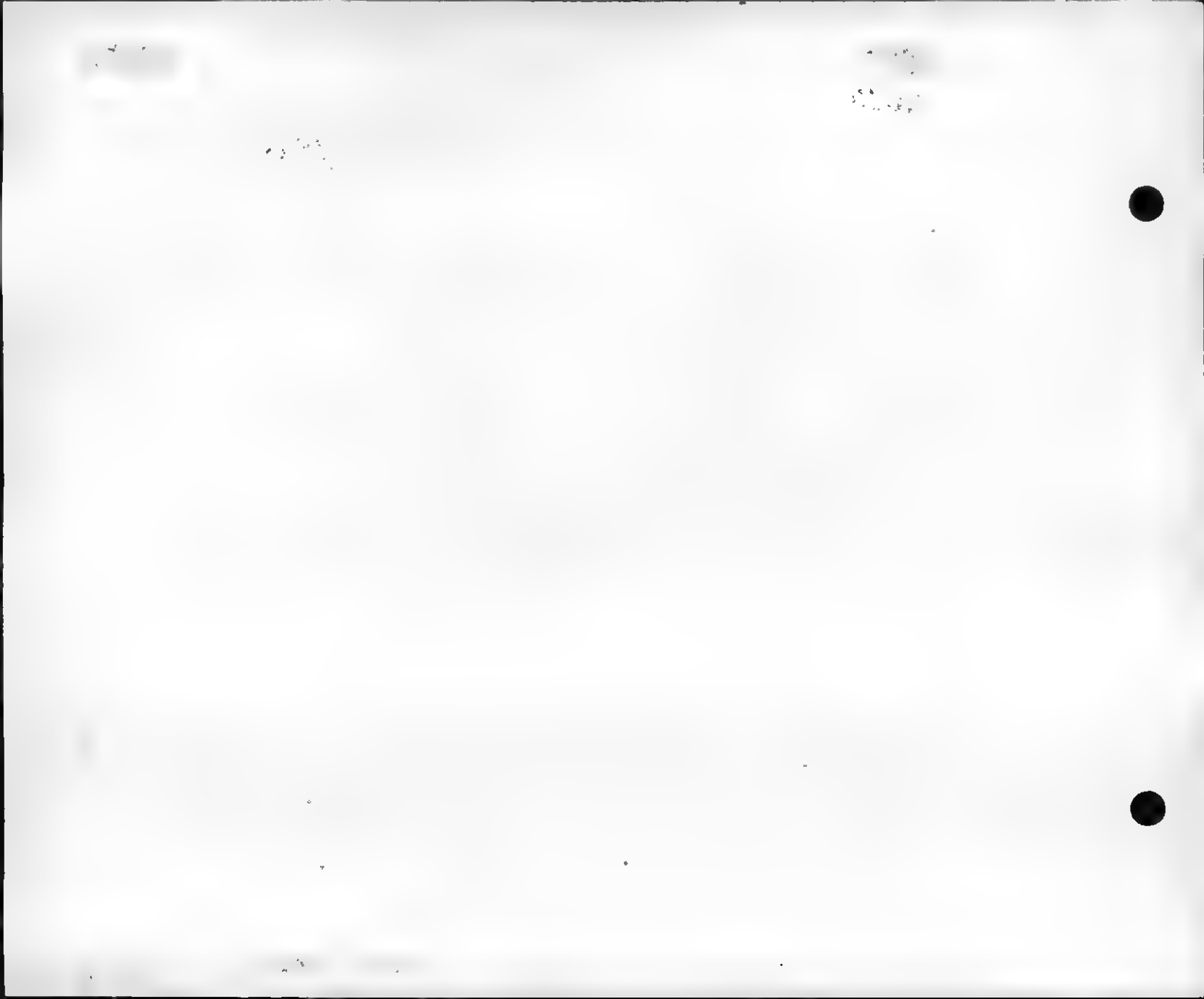
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04672

CERTIFICATE OF DEATH

04672

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c LENGTH OF STAY IN 1b <b>30.4</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e STREET ADDRESS <b>4017 Biddison Lane</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Jacqueline Elizabeth BENNETT</b>				4 DATE OF DEATH Month Day Year <b>April 26, 19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 19, 1967</b>		9 AGE (In years last birthday) <b>7</b> yrs.	10a IF UNDER 1 YEAR Months Days Hours Min <b>7</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Norman Michael Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Marlene Yvonne Manzione</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>NONE</b>		17 INFORMANT <b>MR. NORMAN N BENNETT</b>		Address <b>(SAME)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Previabile premature</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>April 19, 19 67</b> to <b>April 26, 19 67</b> that <b>(A)</b> (we) last saw the deceased alive on <b>April 26, 19 67</b> , and that death occurred at <b>3:15 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Jose Aguto</b>		MD ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 26, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Jose Aguto, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy REDEEMER CEM.</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE Md.</b>	
24 FUNERAL DIRECTOR <b>LEONARD J. RUCK, INC. BALTO. Md. 21214</b>				25a REC'D BY REGISTRAR <b>APR 27 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

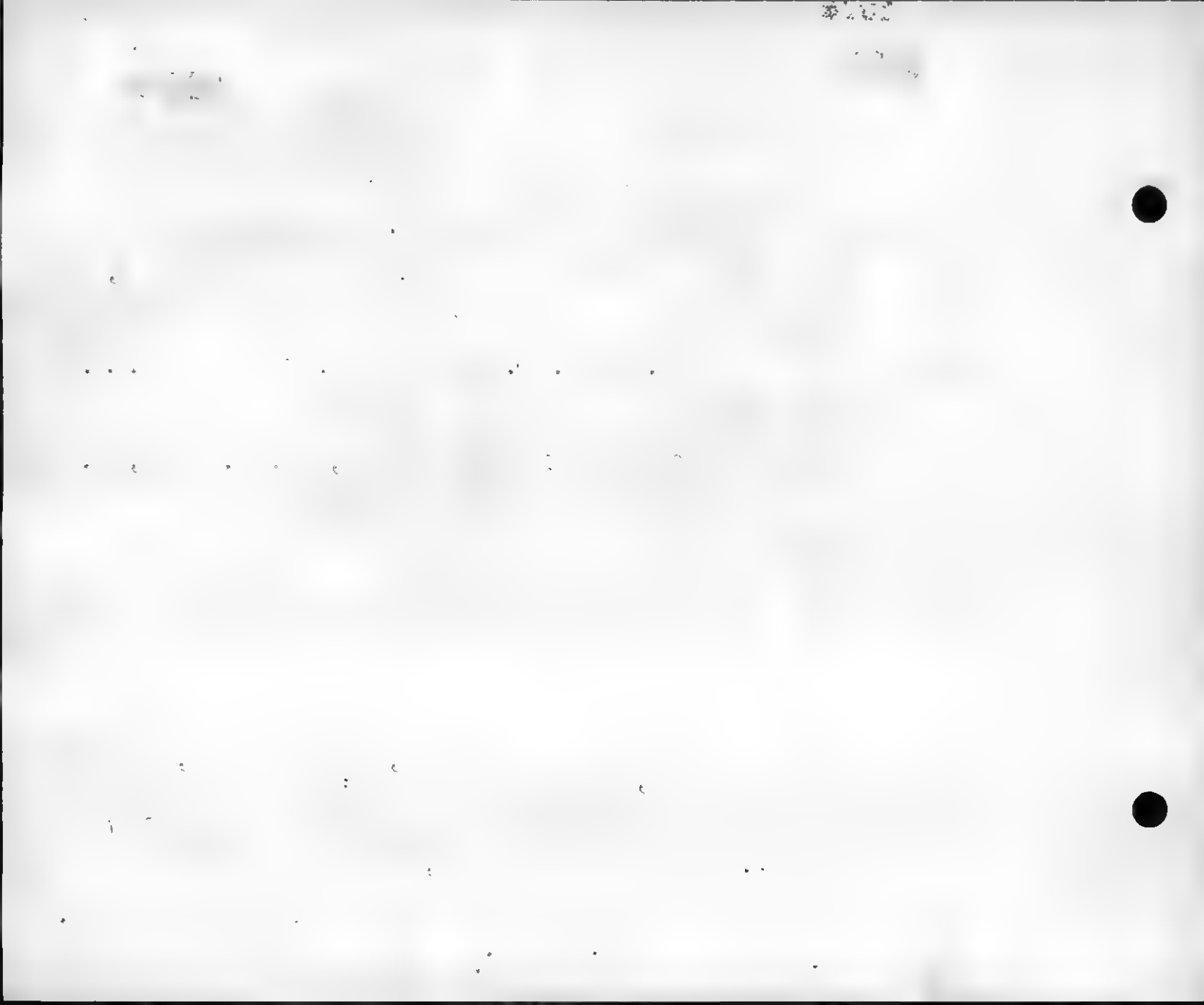
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04673

CERTIFICATE OF DEATH

04673

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>14 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>RAYMOND</b> Last <b>BLIZZARD</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/02</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SIGN DISPLAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NAT'L. ADVERT. CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CARROLLTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JEREMIAH BLIZZARD</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN MARTIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>214 03 73 61</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG WITH METASTASES</b> X <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 18, 19 67</b> to <b>APRIL 1, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 1, 19 67</b> , and that death occurred at <b>2:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED <b>4/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA</b>		22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CARROLLTON CHURCH CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>CARROLLTON, CARROLL, MD.</b>
24. FUNERAL DIRECTOR <b>SAFFELL, FUNERAL HOME,</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

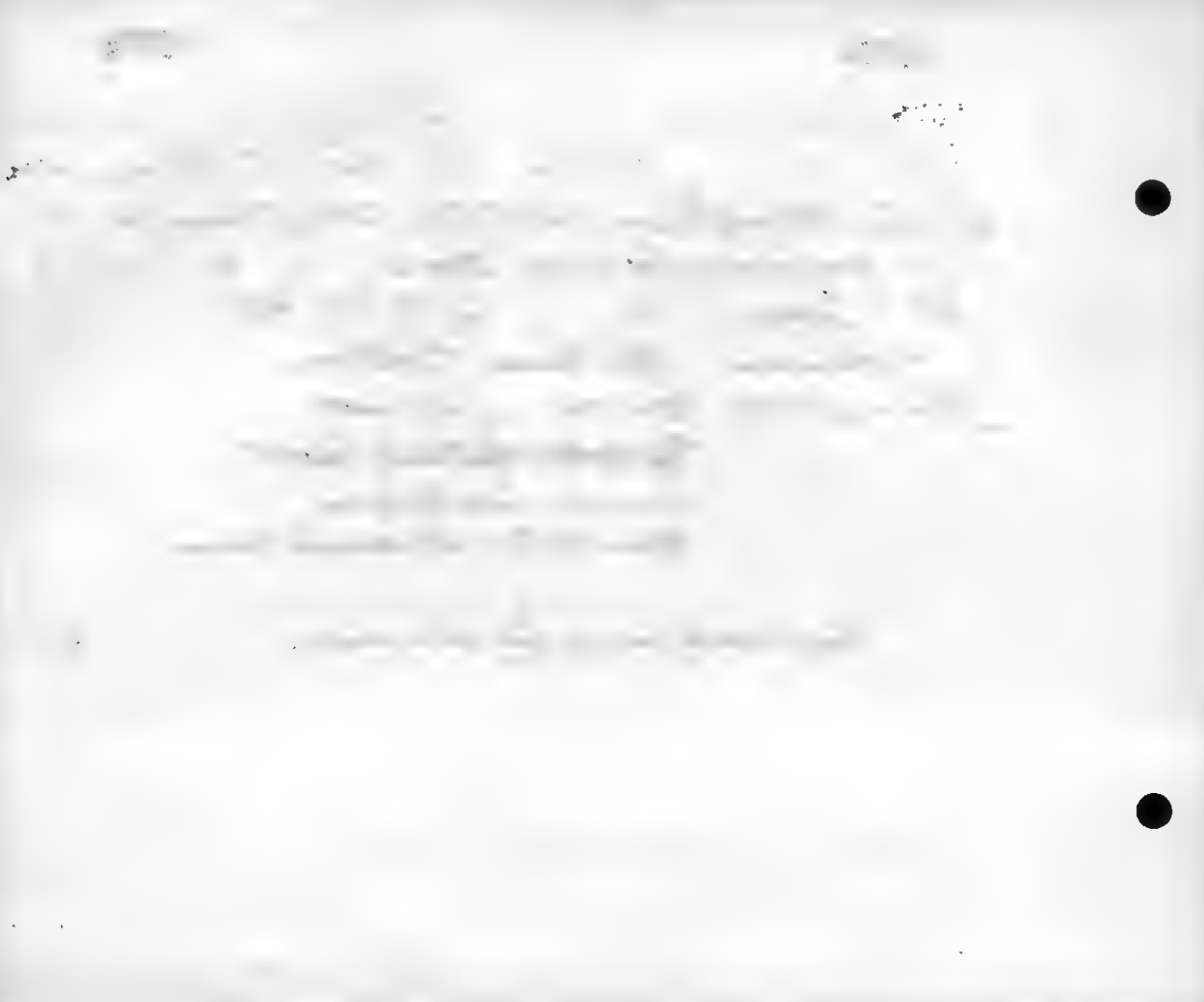
04674

CERTIFICATE OF DEATH

04674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>39 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 2 Box 52 Phoenix Md</u>		d. STREET ADDRESS	
e. NAME OF HOSPITAL OR (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joshua Galbatt Booth</u>		4. DATE OF DEATH <u>4/19/67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/88</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BTO Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Walter Booth</u>		14. MOTHER'S MAIDEN NAME <u>Galbatt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>705-104431</u>	
17. INFORMANT <u>Patient Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>			INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent abdom. surgery for colon cancer</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>67</u> , to <u>April 19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>April 19</u> , 19 <u>67</u> , and that death occurred at <u>1:50 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M. Isabelle MacGregor MD</u>		22b. DATE SIGNED <u>4-19-67</u>	22c. PHYSICIAN'S NAME (Type) <u>ISABELLE MACGREGOR</u>
23a. BURIAL (CREMATION REMOVAL (Specify)) <u>Burial</u>		23b. DATE THEREOF <u>April 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Bethel</u>
23d. LOCATION (City or Town) (County) (State) <u>Carrollton, Carroll Cty. Md.</u>		23e. REC'D BY REGISTRAR	
23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23g. DATE <u>APR 21 1967</u>	
24. FUNERAL DIRECTOR <u>Will. Cook-Brooks Towson</u> 1050 York Road Towson, Maryland 21204			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04675

04675

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>21222</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7546 Rabon Ave.</b>		e. STREET ADDRESS <b>7546 Rabon Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>James Bowers</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/14/1917</b>
9. AGE (in years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b> Hours <b>45</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Factory Guard &amp; Mgr. Bowling Bus.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joshua Bowers</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jefferson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. II</b>	
16. SOCIAL SECURITY NO. <b>215-07-6980</b>		17. INFORMANT Address <b>Balt. 21222</b> <b>Mrs. Charlotte E. Bowers-7546 Rabon Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4201</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C Patterson</b>		22. DATE SIGNED <b>4/24/67</b>	
EXAMINER'S NAME (Type) <b>THEO C PATTERSON</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	23d. LOCATION (City, town or county) (State) <b>6 E. Franklin St. Balt. 21202</b>
24. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. C. [Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000000

1000000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

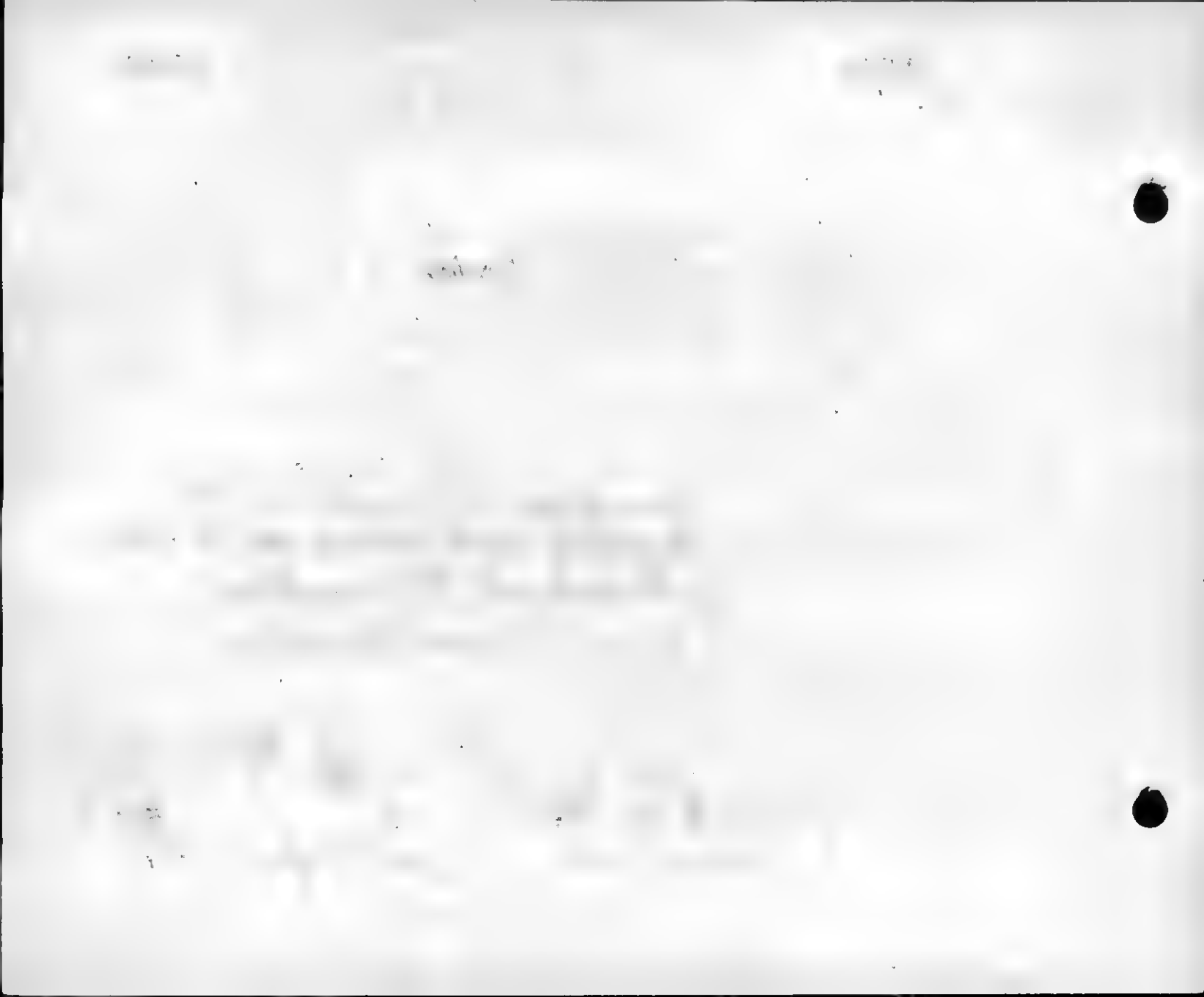
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04676

CERTIFICATE OF DEATH

04676

1 PLACE OF DEATH a COUNTY <u>BALTO</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9744 MagLeet Rd</u>				d. STREET ADDRESS <u>9744 MagLeet Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth R Bowling</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>29</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Rankin</u>				14. MOTHER'S MAIDEN NAME <u>Violet H. Howe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-22-4813</u>		17. INFORMANT <u>Family records</u> Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhagic Anemia with</u> DUE TO (b) <u>Congestive heart Failure due to 1 above</u> DUE TO (c) <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Origin Ovarian Carcinoma</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF DEATH Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospita) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>April</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> , 19 <u>67</u> , and that death occurred at <u>6:10</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>F.T. Kasik Jr. MD</u>				22b. DATE SIGNED <u>5/1/67</u>		22c. PHYSICIAN'S NAME (Type) <u>F.T. KASIK JR.</u>	
22d. ADDRESS <u>9005 Harford Rd.</u>				22e. MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>C.F. EVANS &amp; SON 8802 Harford Bd.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

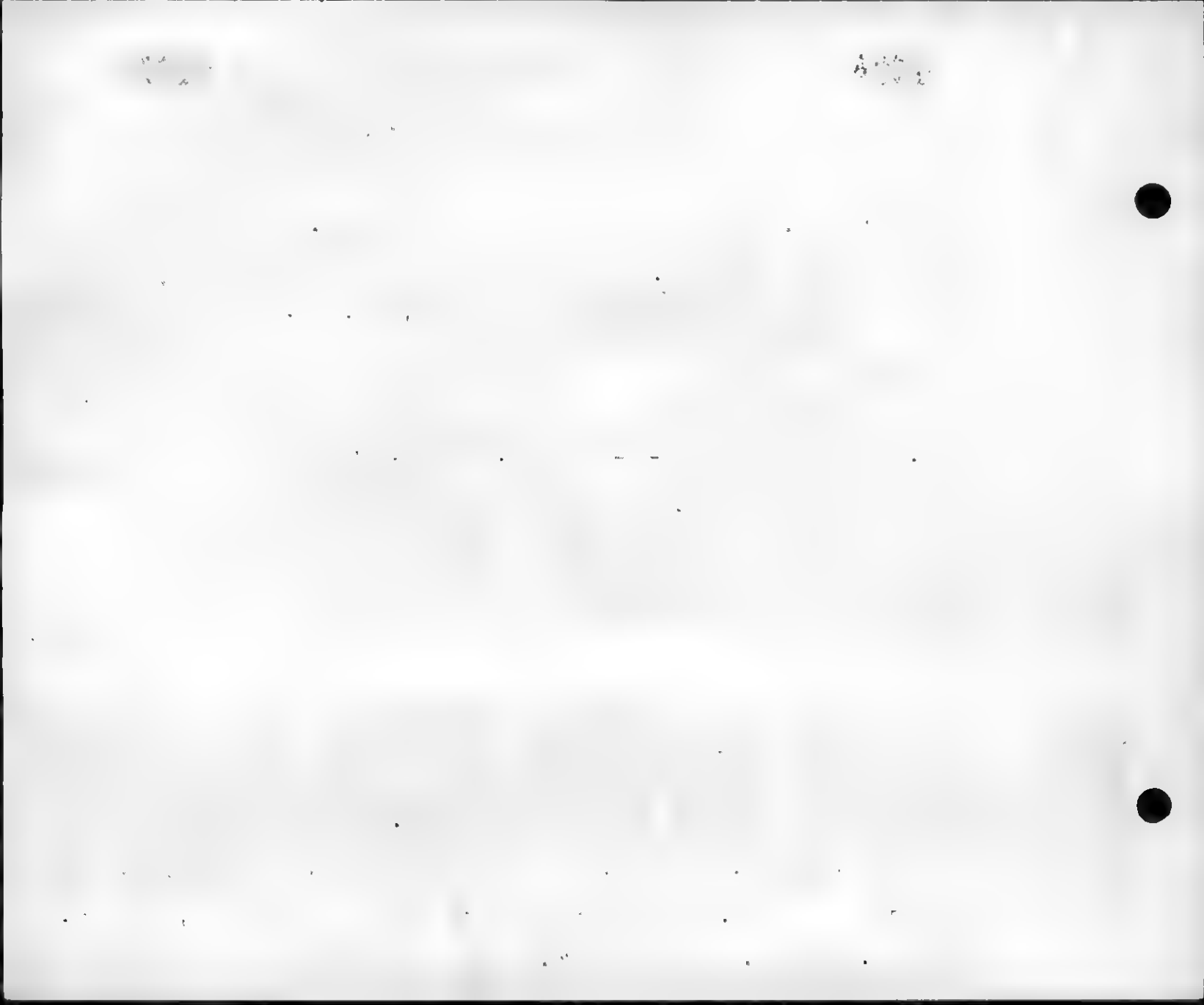
04677

## CERTIFICATE OF DEATH

04677

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Donneybrook</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 Garden Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Donneybrook</u> d. STREET ADDRESS <u>300 Garden Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EARL T. BRADDOCK</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>August 4, 1895.</u> <b>9. AGE</b> (In years) <u>71</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.				<b>4. DATE OF DEATH</b> <u>April 3rd, 1967</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Delaware</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Albert Braddock</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Lillie May Taylor</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Unk.</u> <b>16. SOCIAL SECURITY NO</b> <u>218-07-9611</u> <b>17. INFORMANT</b> <u>Mrs. Norma L. Braddock</u> Address <u>(Same)</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>H.A.S.C.V.D. &amp; old left C.V.A. (hemiplegia)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JULY</u> , 1958, to <u>APRIL</u> , 1967, that (I) (we) last saw the deceased alive on <u>APRIL 2</u> , 1967, and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above. <b>22a. SIGNATURE</b> <u>Carlton L. Sexton</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>4-4-67</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Carlton L. Sexton, M.D.</u> <b>22d. ADDRESS</b> <u>819 Park Ave., Baltimore, Md. 21201</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>4/6/67.</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Silver Run Brook Cemetery</u> <b>23d. LOCATION (City or town) (County) (State)</b> <u>Wilmington, Delaware.</u> <b>24. FUNERAL DIRECTOR</b> <u>Leonard J. Ruck Inc. 5305 Harford Rd. #14</u> ADDRESS <b>25a. REC'D BY REGISTRAR</b> <u>APR 4 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>John E. Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04678

CERTIFICATE OF DEATH

04678

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>?</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Brandt</u> Last <u>Brandt</u>				4 DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1890?</u>	9 AGE (In years) <u>187</u> birthday) yrs	10 IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u>0</u> Min <u>0</u>		11 IF UNDER 24 HRS Months <u>0</u> Days <u>17</u> Hours <u>0</u> Min <u>0</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Unkown</u>				14 MOTHER'S MAIDEN NAME <u>Unkown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>219-54-3038</u>		17 INFORMANT <u>Records: Spring Grove State Hospital</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>Arteriosclerosis, generalized and severe</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and dehydration</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <u>August 14, 1960</u> , to <u>April 28, 1967</u> , that (b) (we) last saw the deceased alive on <u>April 28, 1967</u> , and that death occurred at <u>1:30</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>Stella Wachsler</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> P. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-28-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M.D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Maryland 21228</u>					
23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION <u>Burial</u>		23b. DATE THEREOF <u>5 May 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City or Town) (County) (State) <u>Old Frederick Road, Baltimore</u>	
24. FUNERAL DIRECTOR <u>Kraus Funeral Home</u>		ADDRESS <u>12165 Charles</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

muscle

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muscle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

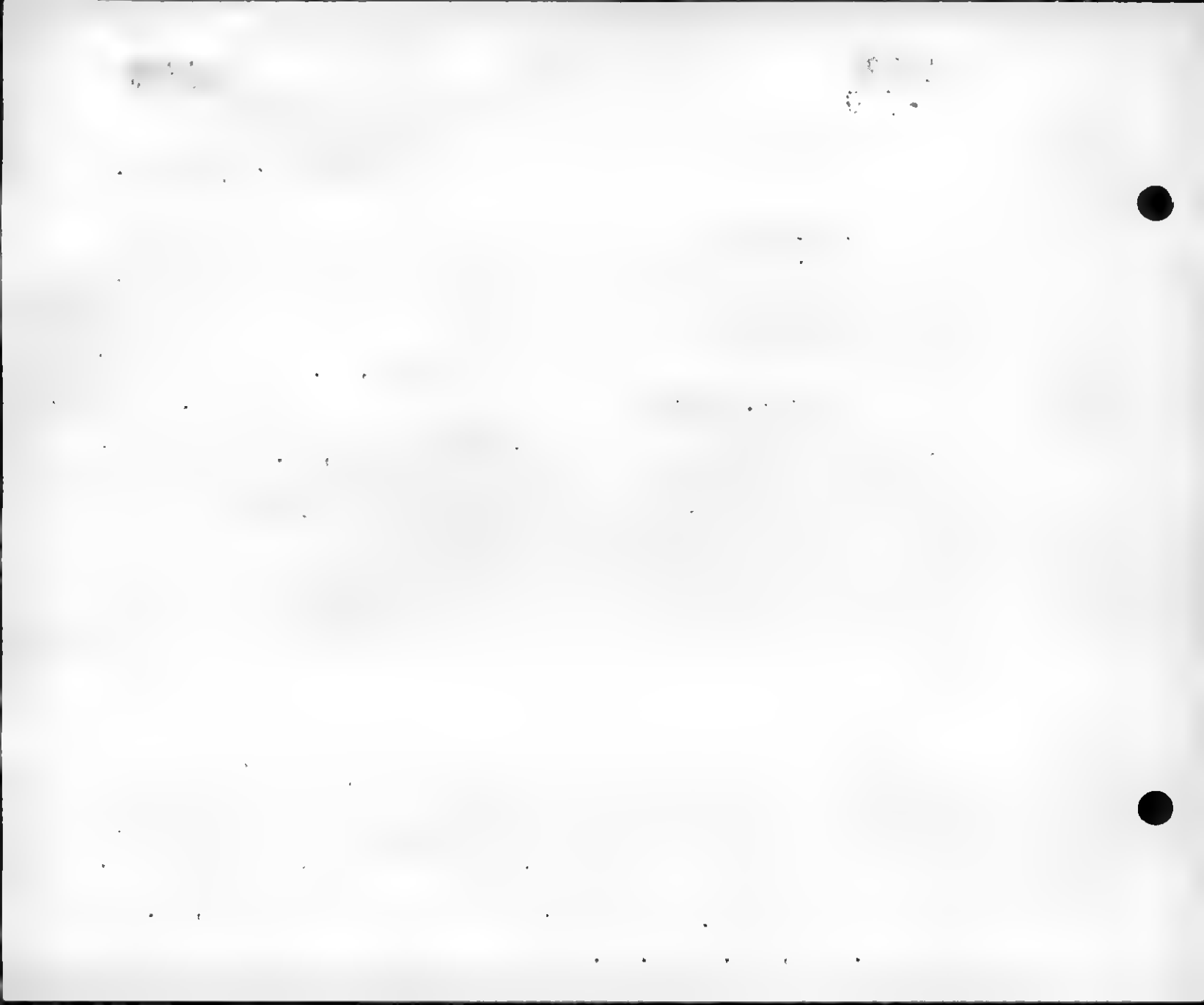
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04679

CERTIFICATE OF DEATH

04679

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Warrington (St. Thomas More Convent)</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Joseph - 4</b>		c. LENGTH OF STAY IN 'b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Warrington (St. Thomas More Convent)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>M. First Middle Last</b> <b>(Sister Saint Dorothy OSF) BRENNAN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-15-15</b>	9. AGE (In years last birthday) <b>51</b> yrs	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min		11. IF UNDER 24 HRS. Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George J. Brennan</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth G. Williamson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Sister Margaretta, St. Joseph's Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma due to Ca. of Ovary</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 7<sup>th</sup> 1967</b> to <b>April 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 17<sup>th</sup> 1967</b> , and that death occurred at <b>11:10 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Freidoon Malek</i> M.D.				22b. DATE SIGNED <b>April 17, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Freidoon Malek M.D.</b>	
22d. ADDRESS <b>7620 York Road, Towson 21204, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/21/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>APR 19 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13 Film #G388 09/167 ps

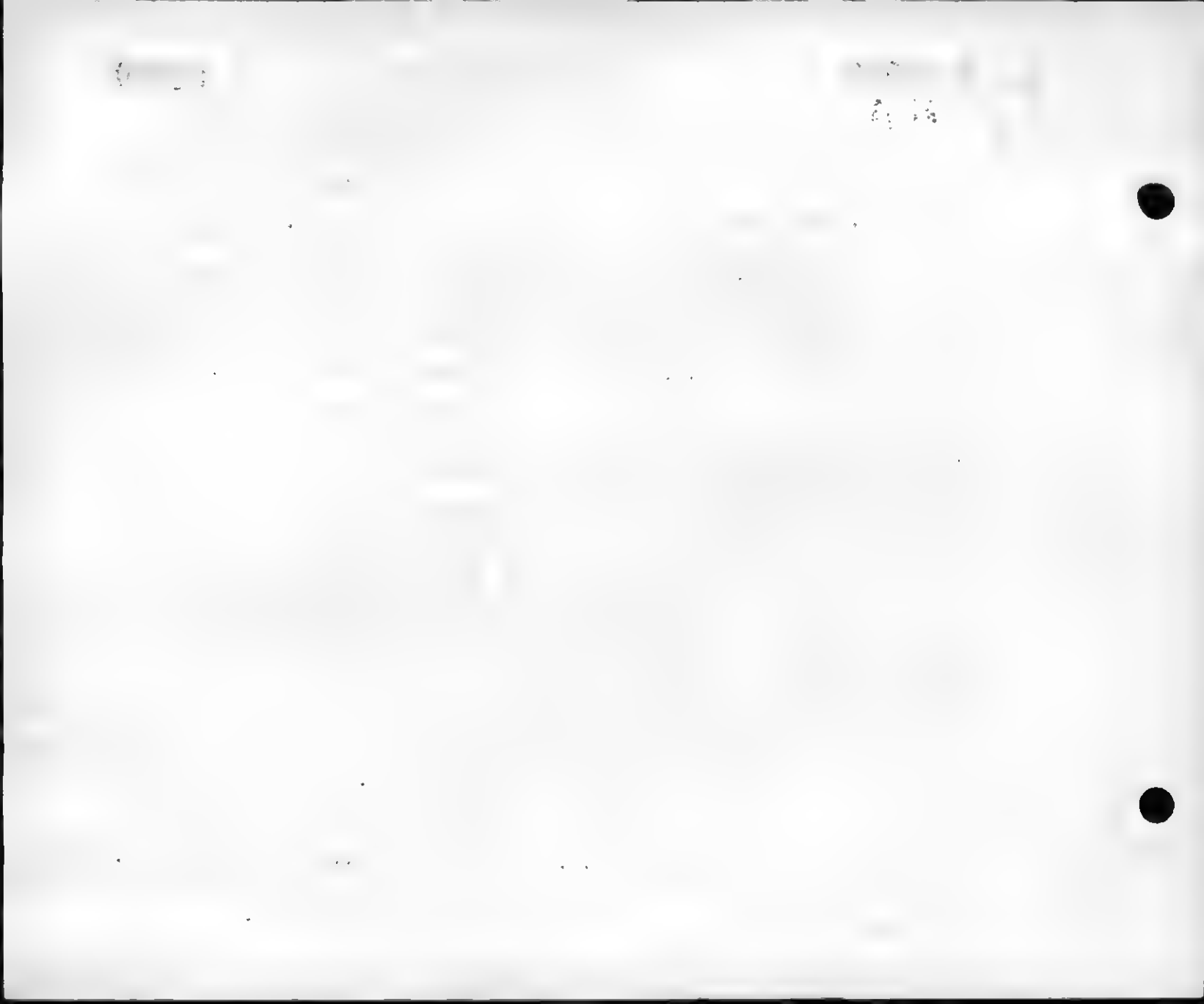
04680

## CERTIFICATE OF DEATH

04680

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>9607 Harding Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>B.</b> Last <b>Bridges</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <b>82</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Steamfitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>H.E. Crook</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>
13. FATHER'S NAME <b>UNKNOWN / Issias Bridges</b>		14. MOTHER'S MAIDEN NAME <b>Mary *****</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>214-01-7502</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia - bilateral</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 17, 19 67</b> , to <b>April 22, 19 67</b> , that (I) (we) last saw the deceased alive on <b>April 22, 19 67</b> , and that death occurred at <b>5:30A</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Efrain L. Reyes</i> M.D.		22b. DATE SIGNED <b>April 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Efrain L. Reyes M.D.</b>		22d. ADDRESS <b>7620 York Road-Towson 21204, Maryland</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balto Md.</b>
24. FUNERAL DIRECTOR <b>CHAS F. EVANS + Son</b>		25a. REC'D BY REGISTRAR <b>8802 Harford Rd</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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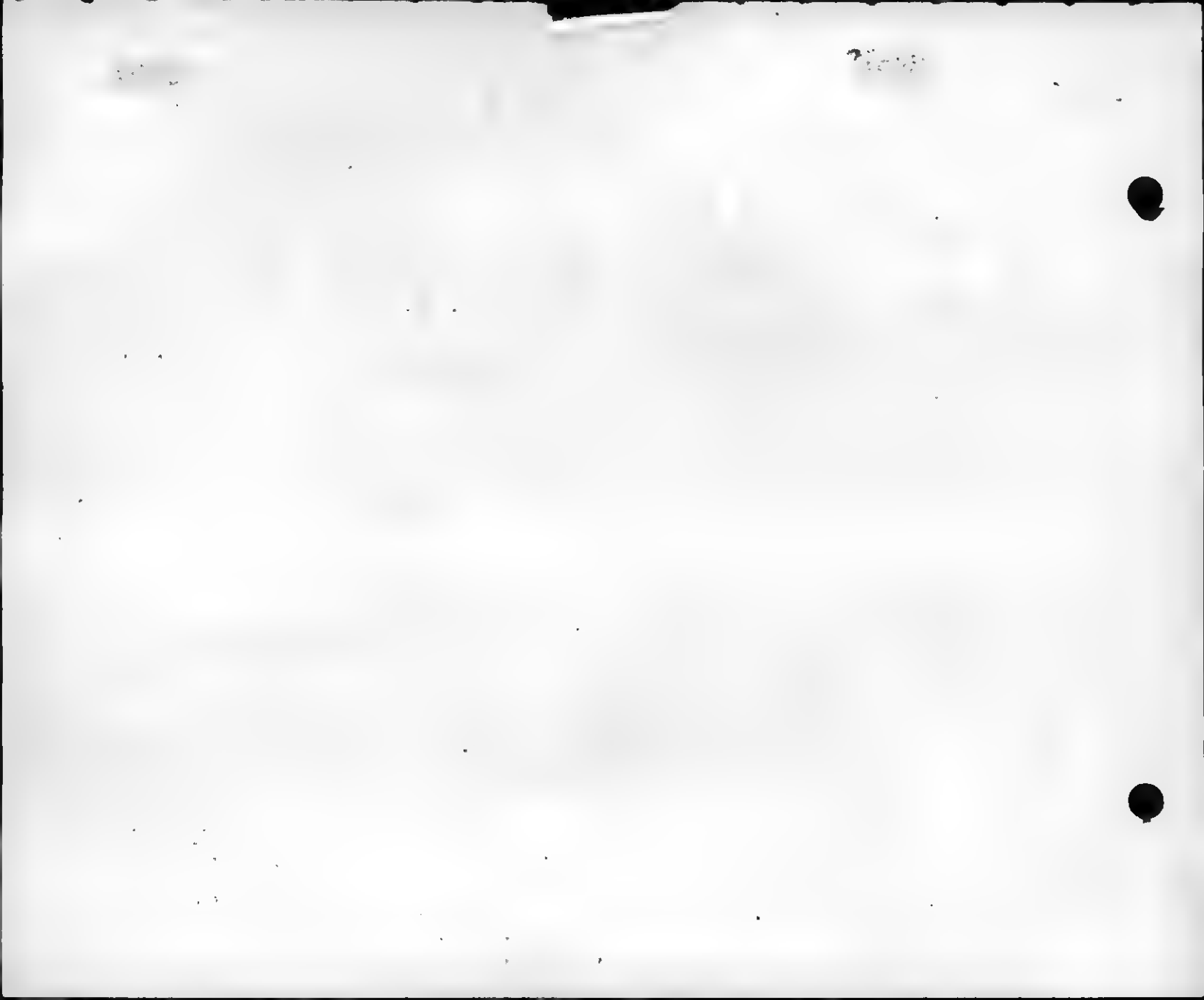
VR A15 (4)  
 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04681

04681

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN ID <b>7yr4mth25dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>5517 Nicholson Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Mary</b> Last <b>Brosnan</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1967</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 21, 1893</b>	
9. AGE (in years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Timothy Warren</b>				14. MOTHER'S MAIDEN NAME <b>MaryLeane</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 50 8678</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH <b>20 days</b> <b>8 years</b> <b>10 "</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, Pneumonia, Arteriosclerotic Endarteritis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Nov. 25, 1959</b> to <b>4/22, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/22/67</b> 19__, and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Narciso W. Carmona</b>				22b. DATE SIGNED <b>4/23</b>		22c. PHYSICIAN'S NAME (Type) <b>NARCISO W. CARMONA</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>				22e. ADDRESS <b>Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>				25a. REC'D BY REGISTRAR <b>APR 25 1967</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

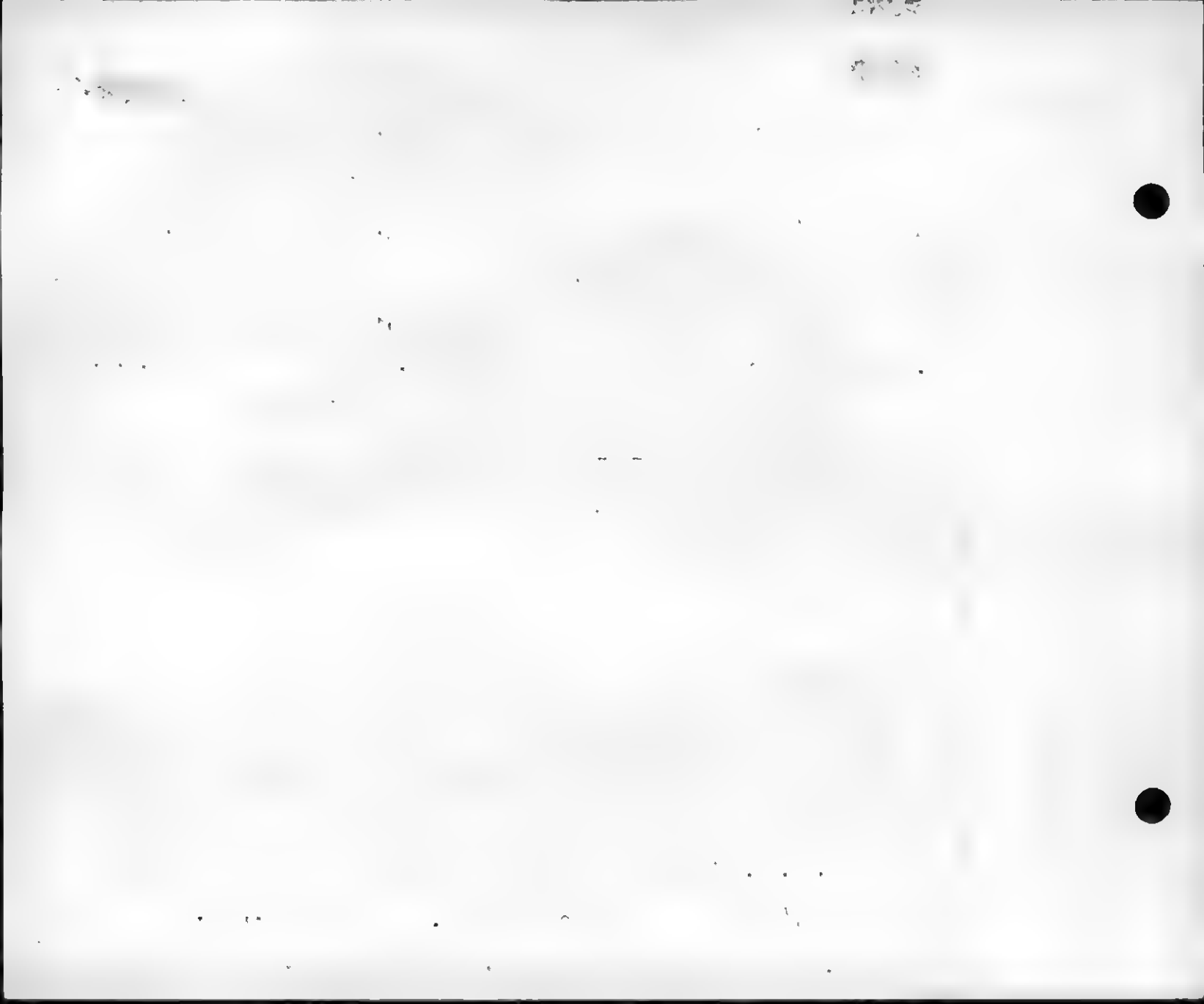
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04682

CERTIFICATE OF DEATH

04682

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>---</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY in 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1302 E. Belvedere Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>E.</u> Last <u>Buckey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 12, 1890</u>
9. AGE (In years last birthday) <u>76</u> yts		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	11. IF UNDER 24 HRS Hours <u>---</u> Min <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Ret. Sales Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sales</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Buckey</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia Runge</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u>212-10-8007A</u>		17. INFORMANT <u>Mrs Pauline Buckey</u> Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>H A S H D</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>570 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>---</u> 19 <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>67</u> , to <u>4/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>67</u> , and that death occurred at <u>3P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. I. S. Zinberg</u>		22d. ADDRESS <u>4000 W. Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04683

CERTIFICATE OF DEATH

04683

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(R) Towson</u>		c. LENGTH OF STAY IN TB <u>16 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Bowleys Quarters</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>			d. STREET ADDRESS <u>5428 Sineen Pk Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>NNN.</u> Last <u>BUCZEK</u>			4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-05</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delta Aluminum Co</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Louis Buczek</u>			14. MOTHER'S MAIDEN NAME <u>Sophie Pomykala</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u> <u>no</u>		16. SOCIAL SECURITY NO <u>219-10-4458</u>	17. INFORMANT <u>Taken from Pt's chart (D. Moser R.N.)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> <u>1601</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma with</u> DUE TO <u>carcinomatosis</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-5-1967</u> to <u>4-21-1967</u> that (I) (we) last saw the deceased alive on <u>4-21-1967</u> , and that death occurred at <u>1:40 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>R. K. CHILLAR</u>			22b. DATE SIGNED <u>4-21-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>RAM K CHILLAR</u>			22d. ADDRESS <u>GTR BALTO MED. CENTER BALTO. MD 21204</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>	<u>4/25/67</u>	<u>Holy Cross Cemetery</u>	<u>Dundalk, Balto. Md.</u>		
24. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>			25a. REC'D BY REGISTRAR <u>APR 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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1874



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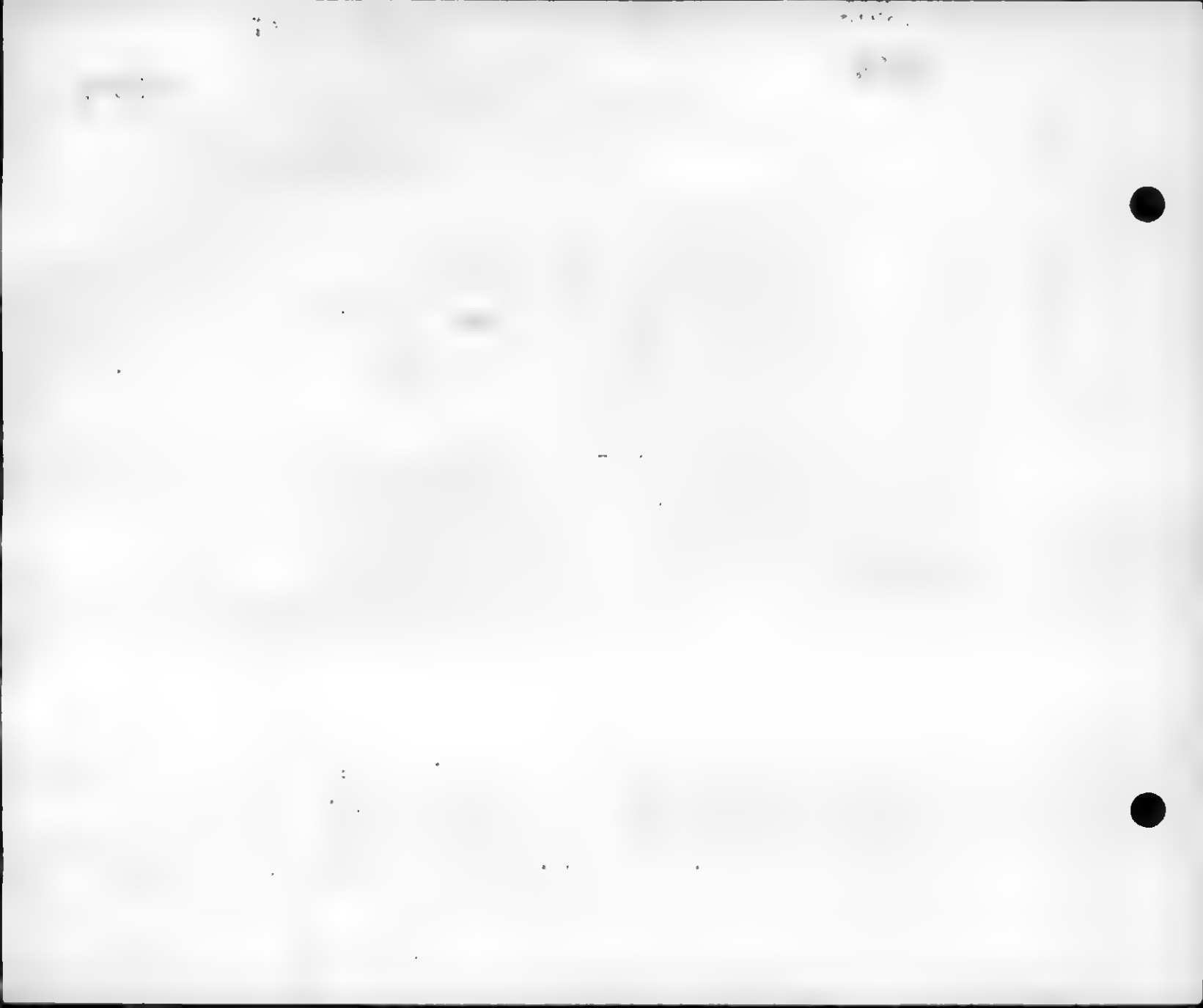
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04684

CERTIFICATE OF DEATH

04684

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>36yr2mth6dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Box 46</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Virginia</b> Last <b>Bullock</b>				4. DATE OF DEATH Month <b>April</b> Day <b>10-</b> Year <b>19 67</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 22, 1884</b>	
9. AGE (In years last birthday) <b>82</b>		10. UNDER 1 YEAR Months <b>8</b> Days <b>2</b>		11. UNDER 24 HRS Hours <b>11</b> Min <b>15</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Va.</b>	
13. FATHER'S NAME <b>Thomas Knox</b>				14. MOTHER'S MAIDEN NAME <b>Mary ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-54-3049</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Feb. 4, 19 31</b> to <b>April 10, 19 67</b> , that (X) (we) last saw the deceased alive on <b>April 10, 19 67</b> , and that death occurred at <b>11:15</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Evelio A. Felipe, M.D.</i>				22b. DATE SIGNED <b>4-11-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Evelio A. Felipe, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 14 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



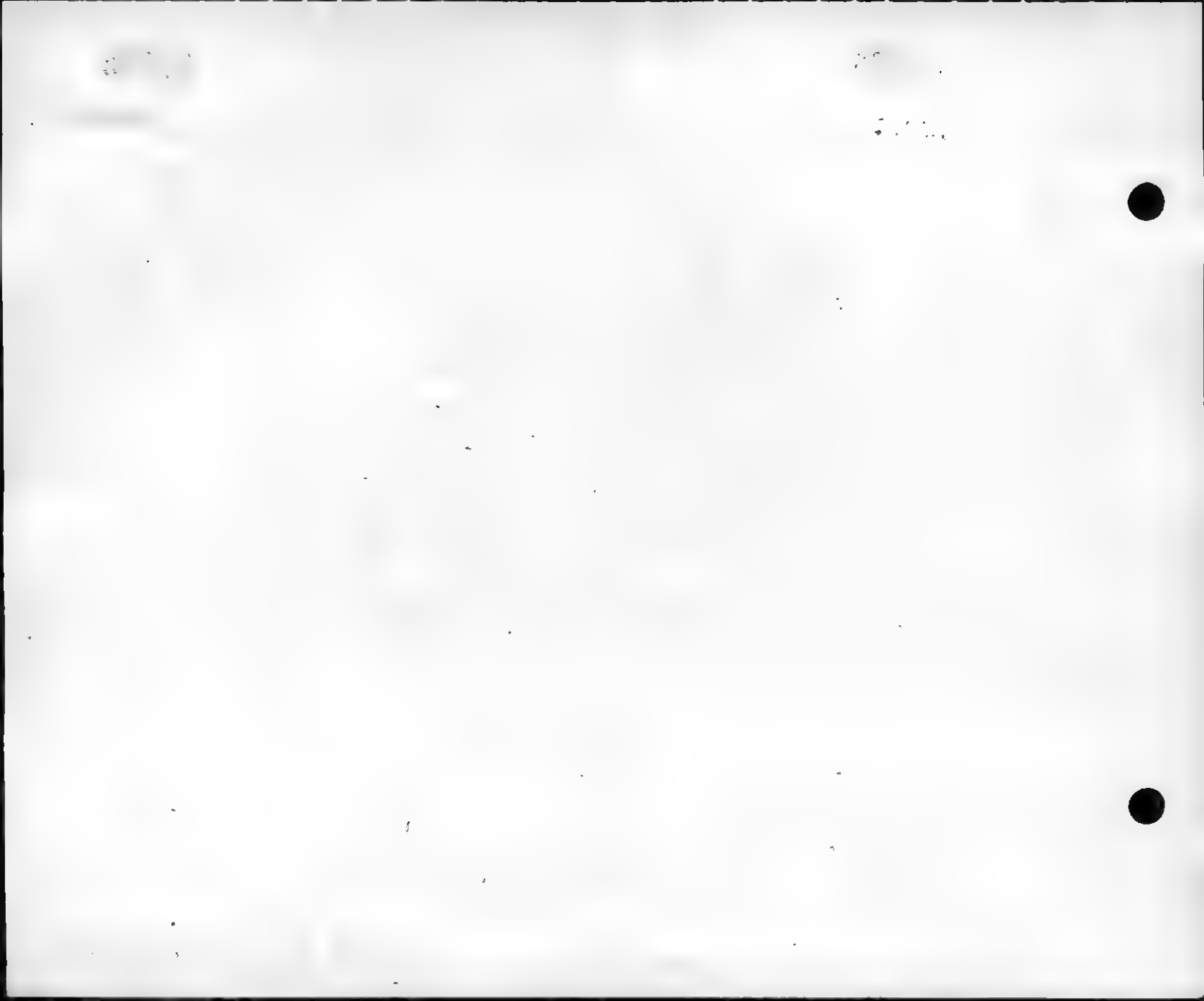
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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04685 CERTIFICATE OF DEATH 04685

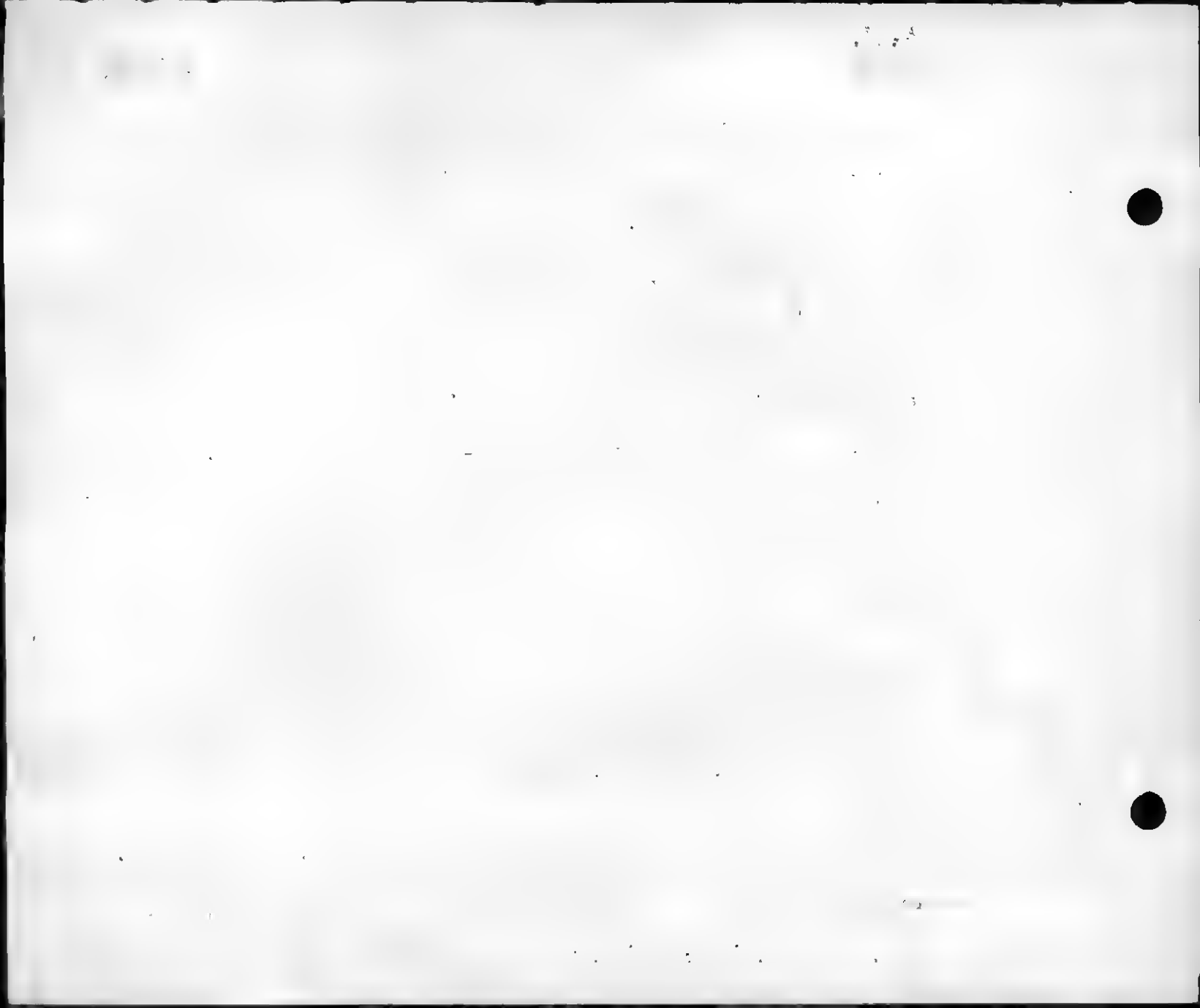
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>			
c. LENGTH OF STAY IN lb <u>18 yrs</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Leslie</u> Last <u>Burke</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15 - 1891</u>	9. AGE (in years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	IF UNDER 24 HRS Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philmore Burke</u>				14. MOTHER'S MAIDEN NAME <u>Camellia Jane Frouble</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W. B. 1st War</u>		16. SOCIAL SECURITY NO. <u>217-05-1076</u>		17. INFORMANT <u>Margie May Burke</u> Address <u>Upperco, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>10 M. 12</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>66</u> , to <u>4/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>67</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Foard</u>				22b. DATE SIGNED <u>4/15/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard MD</u>				22d. ADDRESS <u>MANCHESTER, MD 21102</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Upperco, Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04686						04686					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			Baltimore			a. STATE			Virginia		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Rural - Baltimore			b. COUNTY			Galax		
c. LENGTH OF STAY IN 1b			one week			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Galax		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Shady Nook Nursing Home 1002 N. Roßling Rd						Route #4			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			ADDIE			4. DATE OF DEATH			April 4 19 67		
5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH		
Female			White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			June 13, 1904		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			9. AGE (In years last birthday)			IF UNDER 1 YEAR IF UNDER 24 HRS.		
HOUSEWIFE			HOME			62 yrs.			Months Days Hours Min.		
11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
Virginia						USA					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Elisha Bane Bedsaul						Mary Ellen Ward					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT		
No						224-46-7188			Vaughn-Guynn Funeral Home Galax, Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>											
DUE TO (b) <i>Generalized Metastatic Carcinoma</i>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. p.m. 19											
20d. INJURY OCCURRED											
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 8-30, 1963, to 4-4, 1967, that (I) (we) last saw the deceased alive on 4-2-1967, and that death occurred at 20 A.M. from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR											
ADDRESS											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											



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MARYLAND STATE DEPARTMENT OF HEALTH

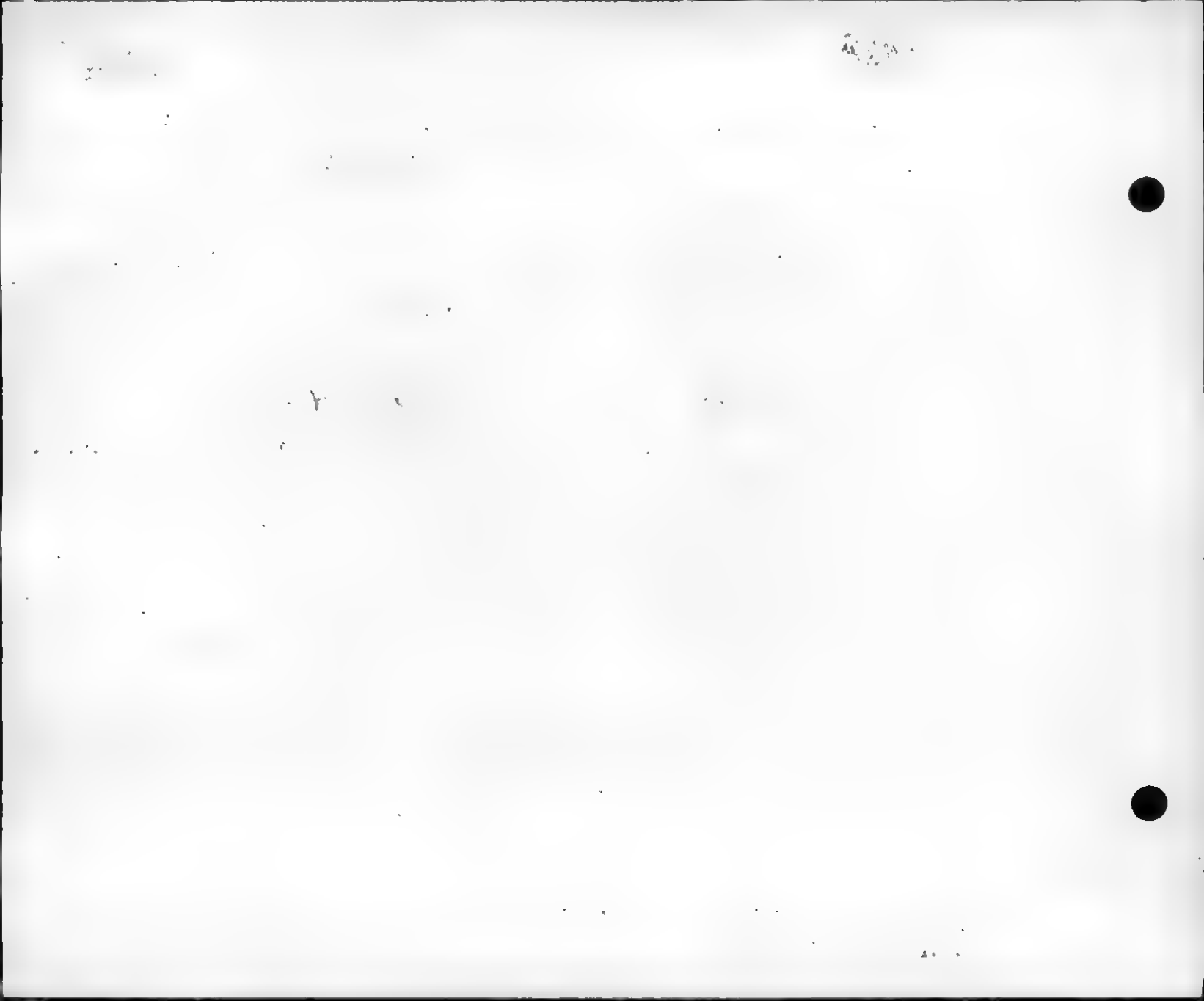
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04687

CERTIFICATE OF DEATH

04687

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicottville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summitt Nursing Home</u>		e. STREET ADDRESS <u>803 Maple Rock Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MURIEL AGNES BUTLER</u>		4. DATE OF DEATH Month Day Year <u>April 15, 1967</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1915</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Weintzger</u>		14. MOTHER'S MAIDEN NAME <u>Muriel Nowack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Alfred Butler, 803 Maple Rock Road, E.C. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 1701 DUE TO (b) <u>METASTATIC BRAIN CANCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>CARCINOMA, BLAST</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 M</u> <u>2 Y</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> , 19 <u>66</u> , to <u>4-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>67</u> , and that death occurred at <u>12<sup>23</sup></u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John V. Thode</u>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-18-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	23d. LOCATION (City, town or county) (State) <u>Ellicott City, Md</u>
24. FUNERAL DIRECTOR <u>F.C. Higginbotham, Ellicott City, Md</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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VR A75 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

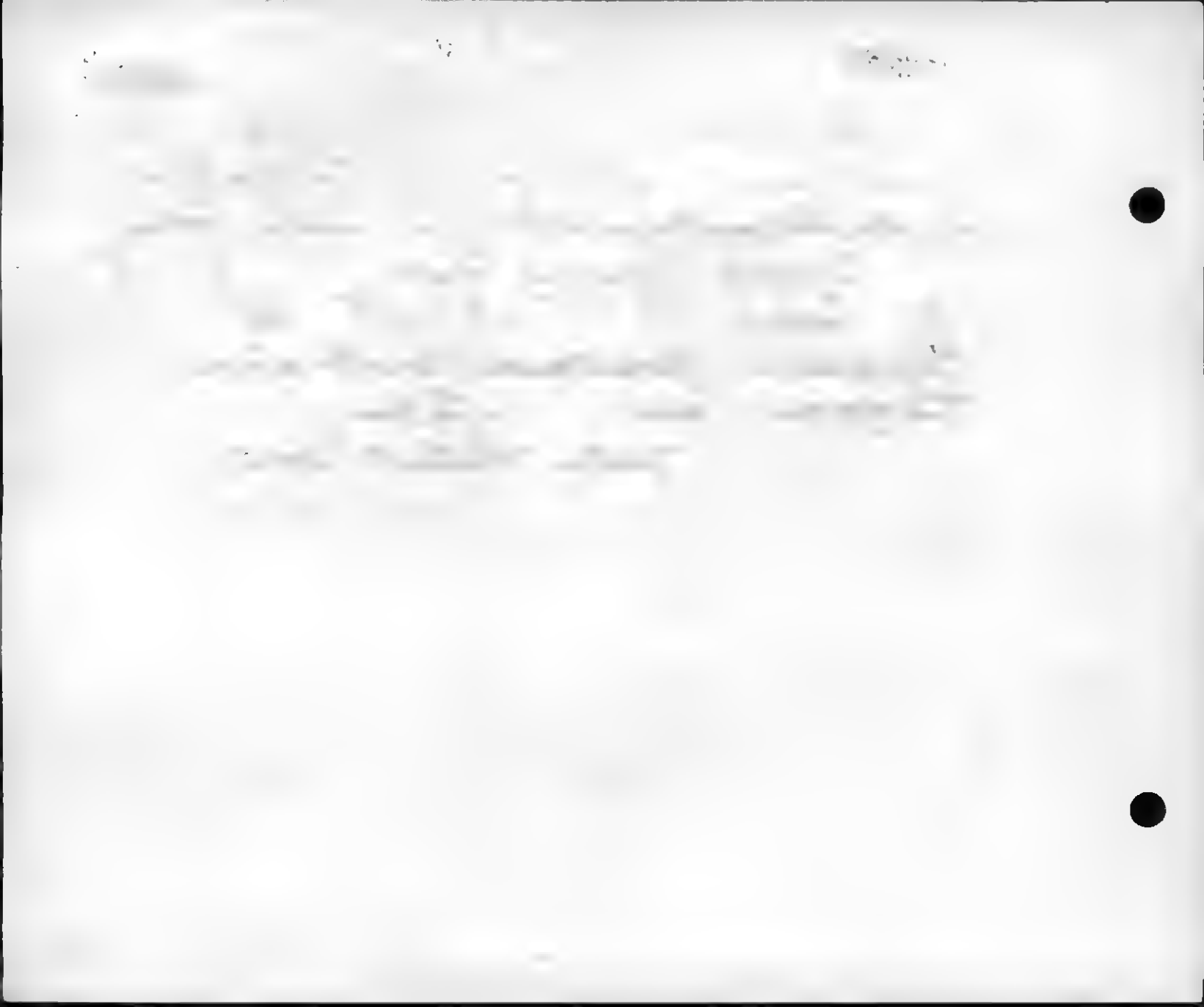
04688

CERTIFICATE OF DEATH

04689

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN lb <u>67 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Virgil Manning Case</u>		4 DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Can</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/6/18</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics</u>		9b KIND OF BUSINESS OR INDUSTRY <u>Martin Marietta</u>	
10a BIRTHPLACE (County & State or foreign country) <u>Dana North Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Benjamin Case</u>		14 MOTHER'S MAIDEN NAME <u>Tabor, Fola Belle</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>394-16-2232</u>	
17 INFORMANT <u>Patient Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma</u> DUE TO (b) <u>of the brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 11, 1967</u> , to <u>April 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 18, 1967</u> , and that death occurred at <u>12:10 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>M. Isabelle MacGregor</u> M.D.		22b DATE SIGNED <u>4-18-67</u>	
22c PHYSICIAN'S NAME (Type) <u>ISABELLE MACGREGOR</u>		22d ADDRESS <u>Gxer. Baltimore Medical Center</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4/21/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Philip F. Gach</u> ADDRESS <u>1211 Chesaco Ave.</u>		25a REC'D BY REGISTRAR <u>APR 20 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>	

BP



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04689

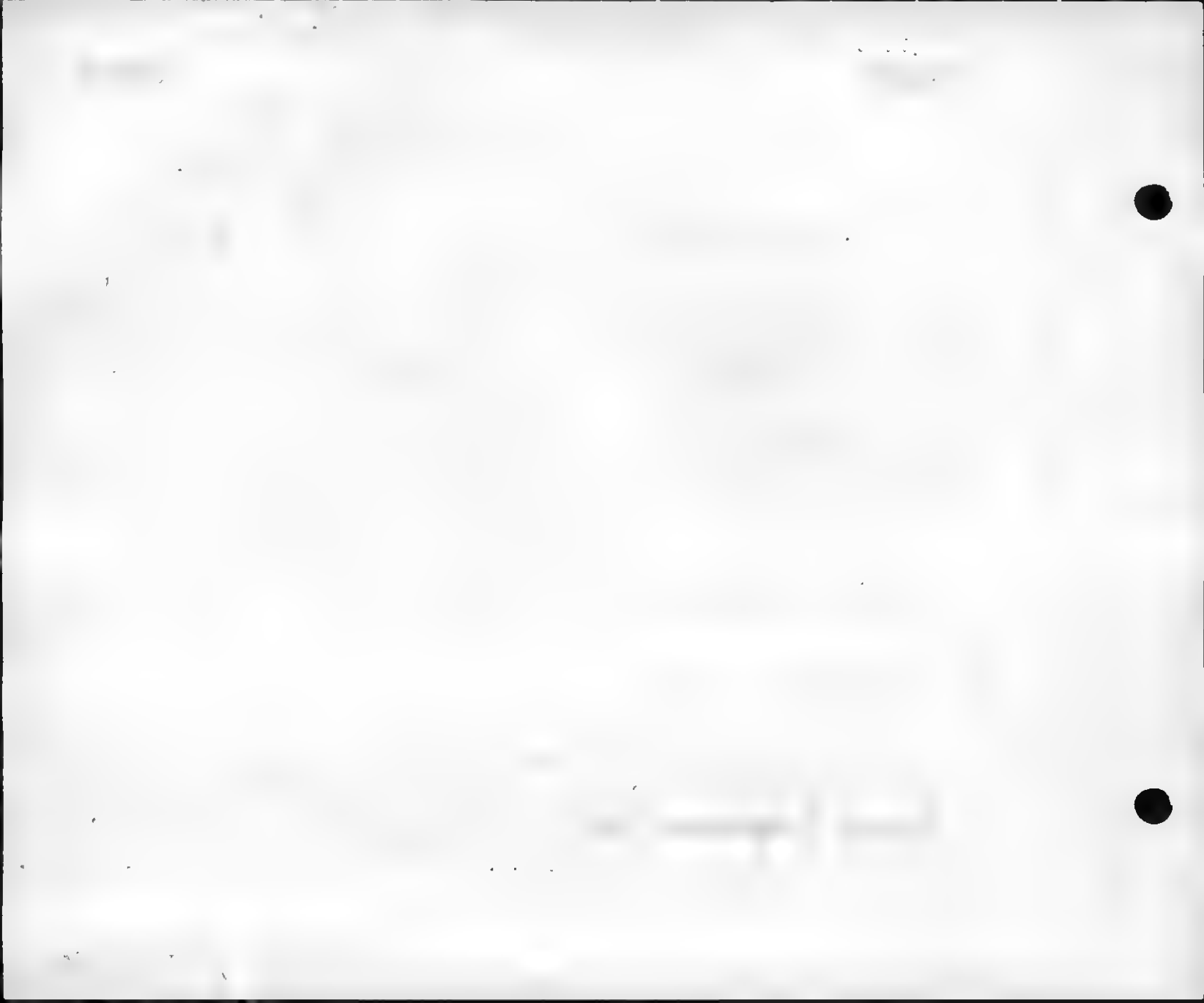
## CERTIFICATE OF DEATH

04690

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>near Towson</b>		c. LENGTH OF STAY IN lb <b>Several weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		24212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1514 Windford Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Coalla Chancey</b>		4. DATE OF DEATH Month Day Year <b>April 11, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-08</b>
9. AGE (In years last birthday) <b>59.58 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer- Salvation Army</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Alfred Doyle</b>		14. MOTHER'S MAIDEN NAME <b>Helia Virginia Irimes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>262-60-9785</b>	
17. INFORMANT <b>Trig. H. I. Chancey (husband)</b>		Address <b>1514 Windford Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 25, 1967</b> , to <b>April 11, 1967</b> that (I) (we) last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>2:00 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Teodoro Paglinawan Jr.</b>		22b. DATE SIGNED <b>April 11, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Teodoro Paglinawan Jr. M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson 21204, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>Apr-14-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West View</b>	23d. LOCATION (City or Town) (County) (State) <b>Atlanta, Ga.</b>
24. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co 106 W North-Av. 21201</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04690

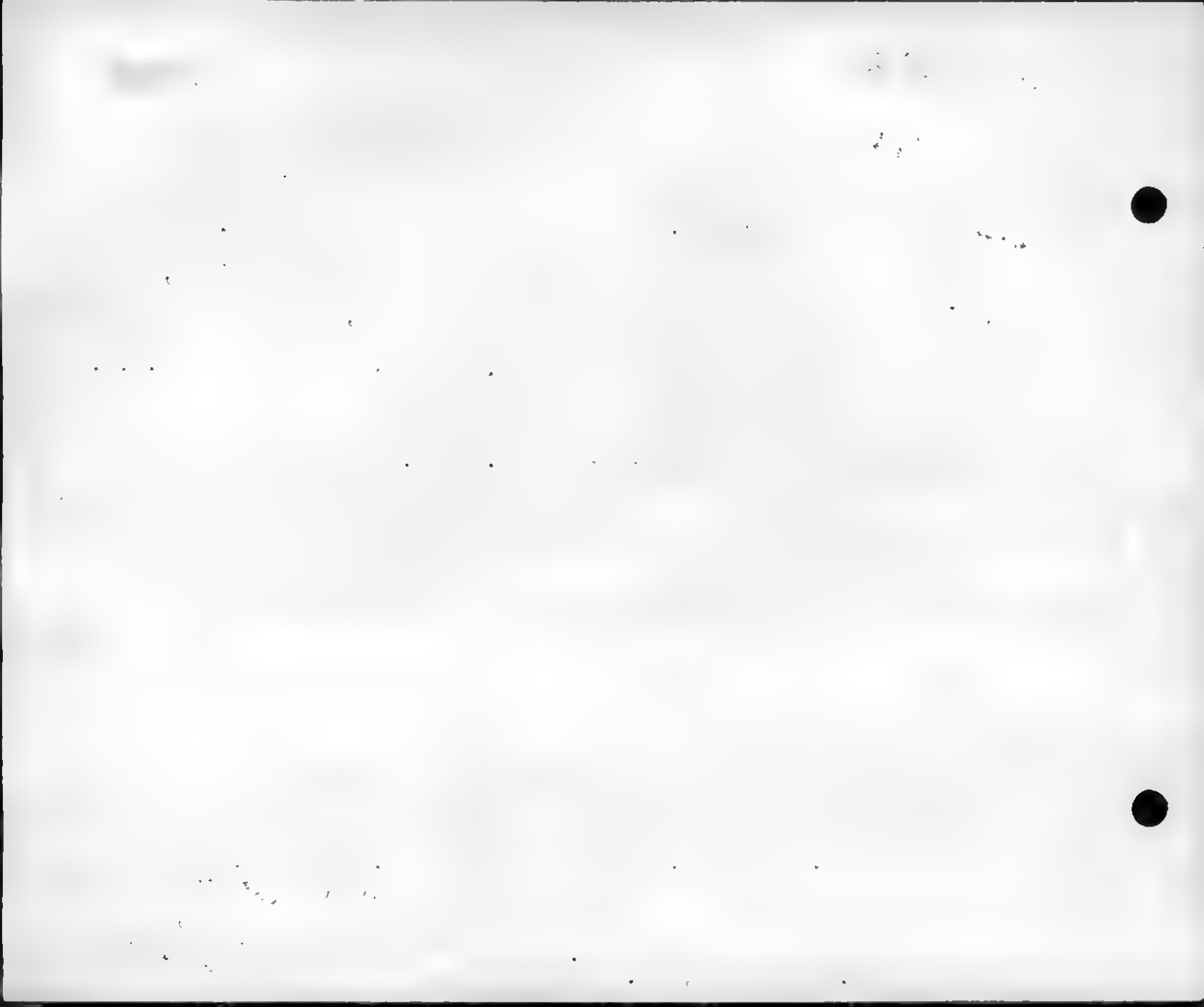
**CERTIFICATE OF DEATH**

04691

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 Dunkirk Rd.</u>		d. STREET ADDRESS <u>70 Dunkirk Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Edward</u> Last <u>Chandler</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>October 23, 1887</u>
9 AGE (In years last birthday) <u>79</u> yrs.		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Keswick Corp.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>London, England</u>	
12 C. TIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Chandler</u>	
14. MOTHER'S MAIDEN NAME <u>Phoebe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>	
16 SOCIAL SECURITY NO <u>109-03-4896</u>		17 INFORMANT <u>A. Mrs. Emily Chandler</u> Same	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerosis</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>15 yrs</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:00</u> <u>PM</u> <u>April 7</u> <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>65</u> to <u>7 Apr</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>6 Apr</u> , 19 <u>67</u> , and that death occurred at <u>4 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Robert E. Mason</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert E. Mason</u>		22d. ADDRESS <u>9 E. Chase St. Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>4-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

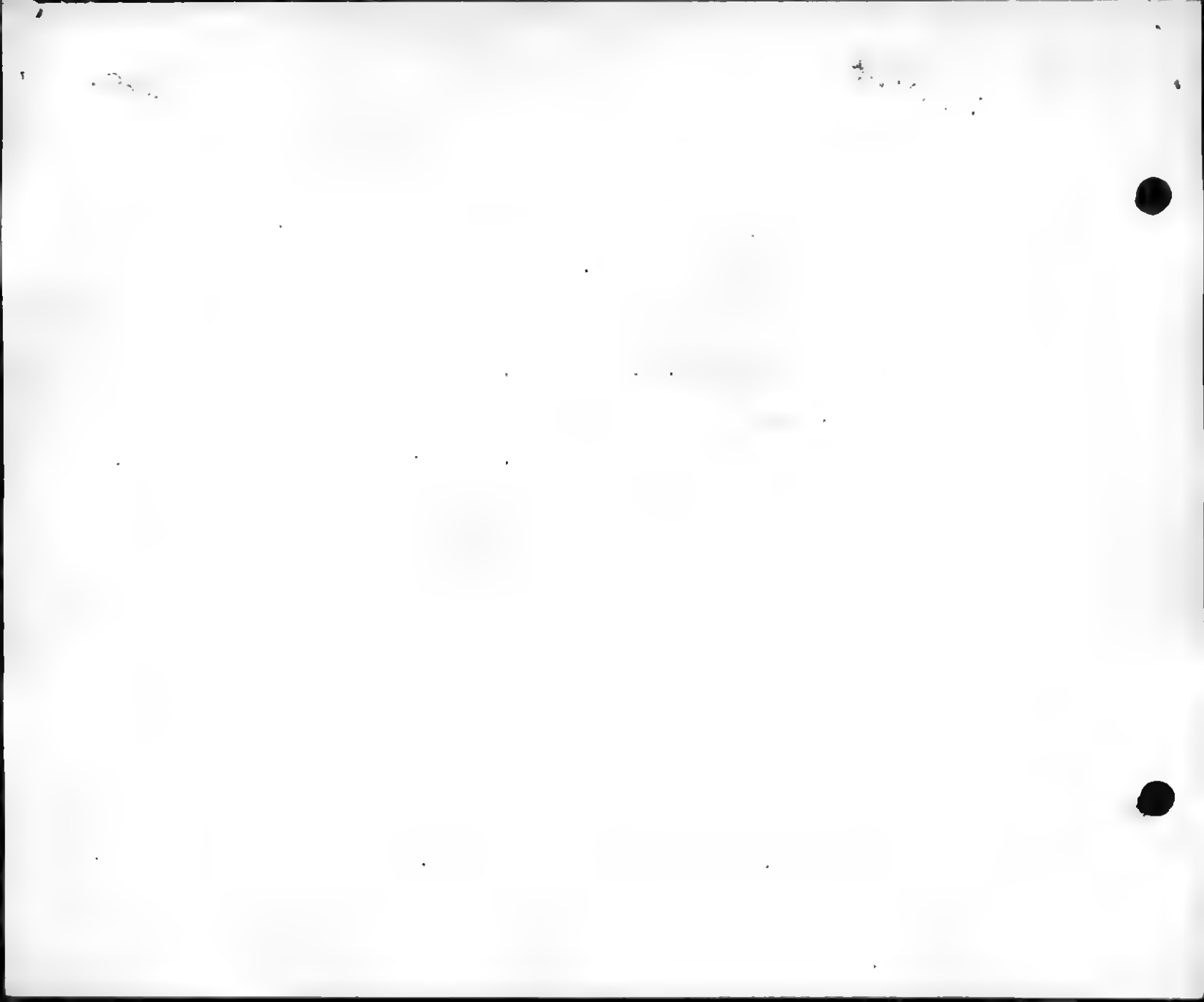
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04692

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b> <b>Catonsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>211 Altamont Ave. 21228</b>		d STREET ADDRESS <b>211 Altamont Ave. 21228</b>	
3 NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>J.</b> Last <b>Clary</b>		4 DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/27/98</b>
9 AGE (In years last birthday) <b>68</b> yrs		10 UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min <b>68</b>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office worker-retired</b>		12 KIND OF BUSINESS OR INDUSTRY <b>Geo. P. Thomas Co.</b>	
13 BIRTHPLACE (State or foreign country) <b>Maryland</b>		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15 FATHER'S NAME <b>Nicholas B. Clary</b>		16 MOTHER'S MAIDEN NAME <b>Unknown</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		18 SOCIAL SECURITY NO <b>216-05-7839</b>	
19 INFORMANT <b>E. Carl Horst</b>		Address <b>211 Altamont Ave. 21228</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Sudden</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James N. Frederick</b>		22. DATE SIGNED <b>4/18/67</b>	
EXAMINER'S NAME (Type) <b>James N. Frederick -1311 Francis Ave</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>4/21/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a REC'D BY REGISTRAR <b>APR 21 1967</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





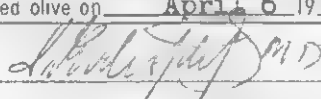

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

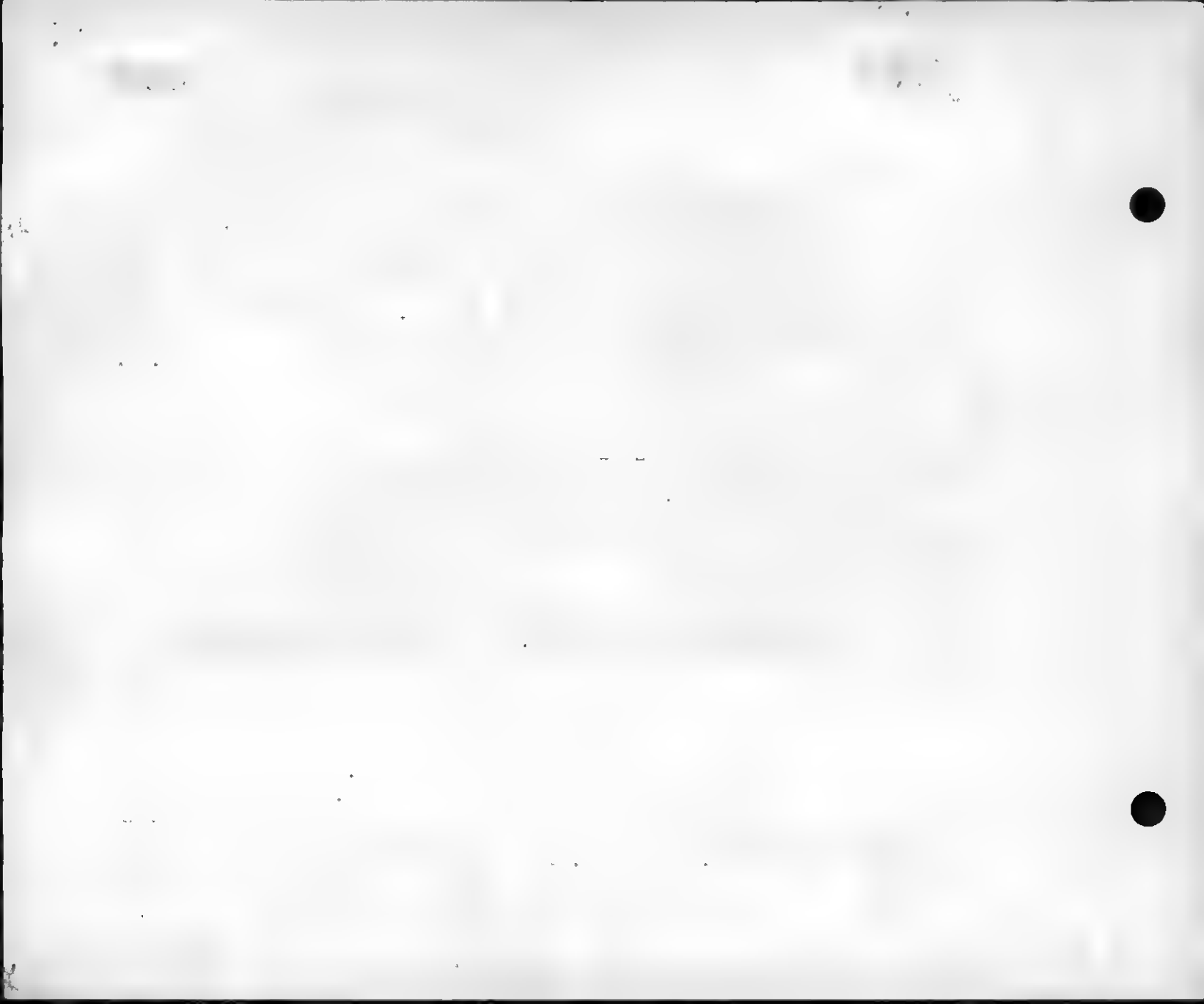


## 04692

## CERTIFICATE OF DEATH

04693

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>633 South Pulaski St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Elizabeth Coburn</b>		4. DATE OF DEATH Month Day Year <b>April 6 19 67</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1895</b>	9. AGE (In years less birthday) yrs <b>71</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Wilbur Kerbe</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Bolandt</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>217-54-0436</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b> DUE TO (b) <b>Cardiac failure</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis</b>						9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (th/s hospital) attended the deceased from <b>March 23, 19 67</b> , to <b>April 6, 19 67</b> that (l) <del>was</del> <b>lost</b> saw the deceased alive on <b>April 6, 19 67</b> , and that death occurred at <b>1:25</b> M, from causes and on the date stated above							
22a. SIGNATURE 		M.D. ATTENDING PHYSY <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSY <input type="checkbox"/>		22b. DATE SIGNED <b>4-6-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Evelio A. Felipe, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE <b>app 10 1967</b></b>		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04693

## CERTIFICATE OF DEATH

Reg. Dist. No. 04694

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BUTLER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BUTLER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Butler Road</u>		d. STREET ADDRESS <u>BUTLER ROAD</u>	
3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>M.</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 9. 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Butler Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R Cole</u>		14. MOTHER'S MAIDEN NAME <u>Laura Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>2-17-23-9254</u>	
17. INFORMANT <u>Nellie Cole</u>		Address <u>BUTLER MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach (Primary)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  67  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>February 5, 1965</u> to <u>Apr 8, 1967</u> , that I last saw the deceased alive on <u>March 28, 1967</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>4-8-67</u>			
ACTUAL SIGNATURE <u>Joseph E. Bush MD</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> <u>HAMPSTEAD MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Butler, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home</u>		ADDRESS <u>Hampstead, Md.</u>	
APPROVED BY REGISTRAR <u>APR 11 1967</u>		DECEASED'S SIGNATURE <u>  </u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

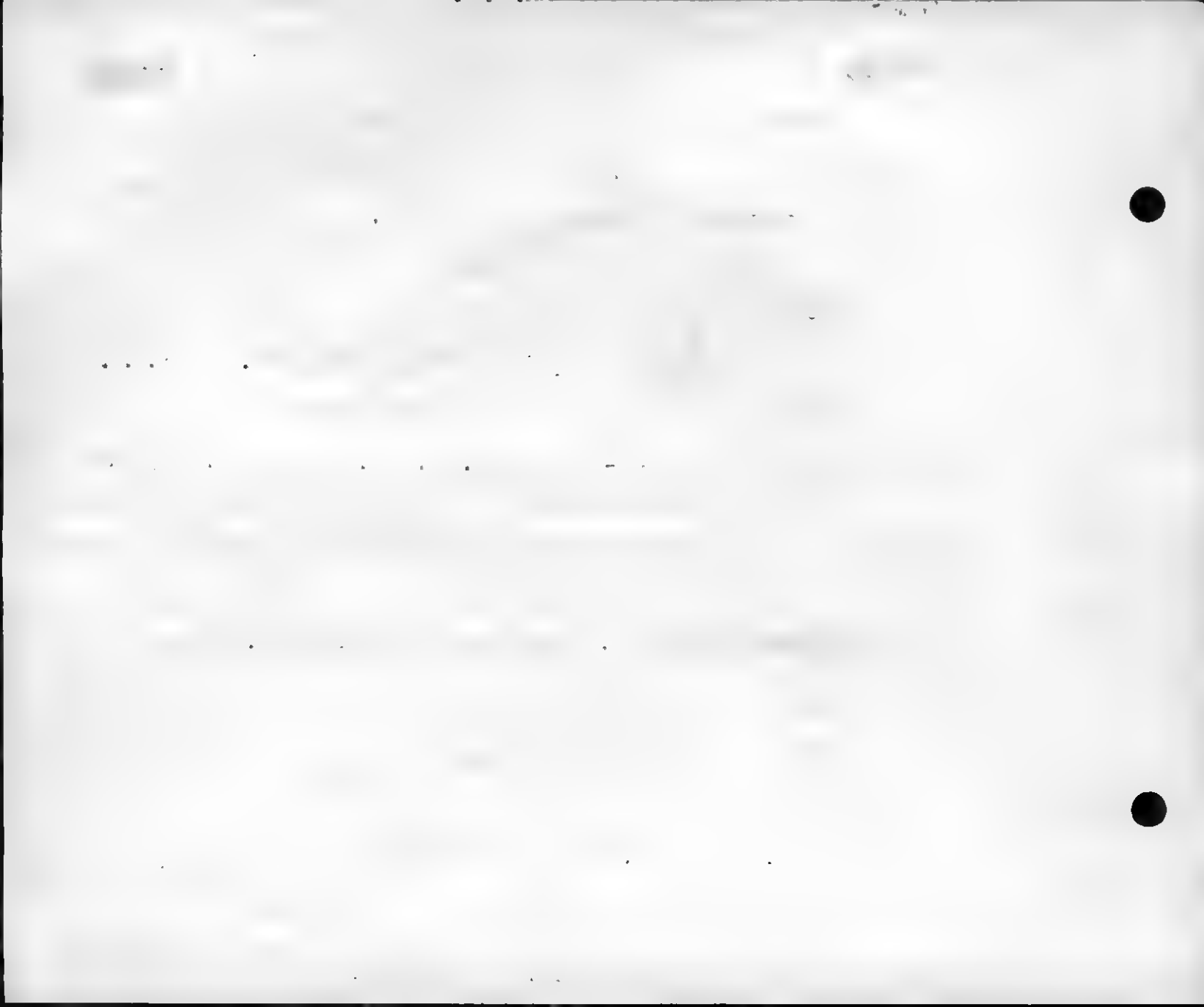
04694

CERTIFICATE OF DEATH

04695

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>		c. LENGTH OF STAY in 1b <b>35 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1732 E. Lanvale Street</b>	
3. NAME OF DECEASED (Type or print) First <b>THEODORE</b> Middle <b>(NMI)</b> Last <b>COLE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/94</b>
9. AGE (In years past birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cole</b>		14. MOTHER'S MAIDEN NAME <b>Laura Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>212-12-03-09</b>	
17. INFORMANT <b>Clin. Rec. VAH, Fort Howard, Maryland</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASES</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS GENERALIZED. BENIGN PROSTATIC HYPERTROPHY. EMACIATION</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> of m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>March 14</b> , 19 <b>67</b> , to <b>April 18</b> , 19 <b>67</b> that <b>10</b> (we) last saw the deceased alive on <b>April 18</b> , 19 <b>67</b> , and that death occurred <b>5:25 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J. D. Talbert</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-21-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Wilson</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



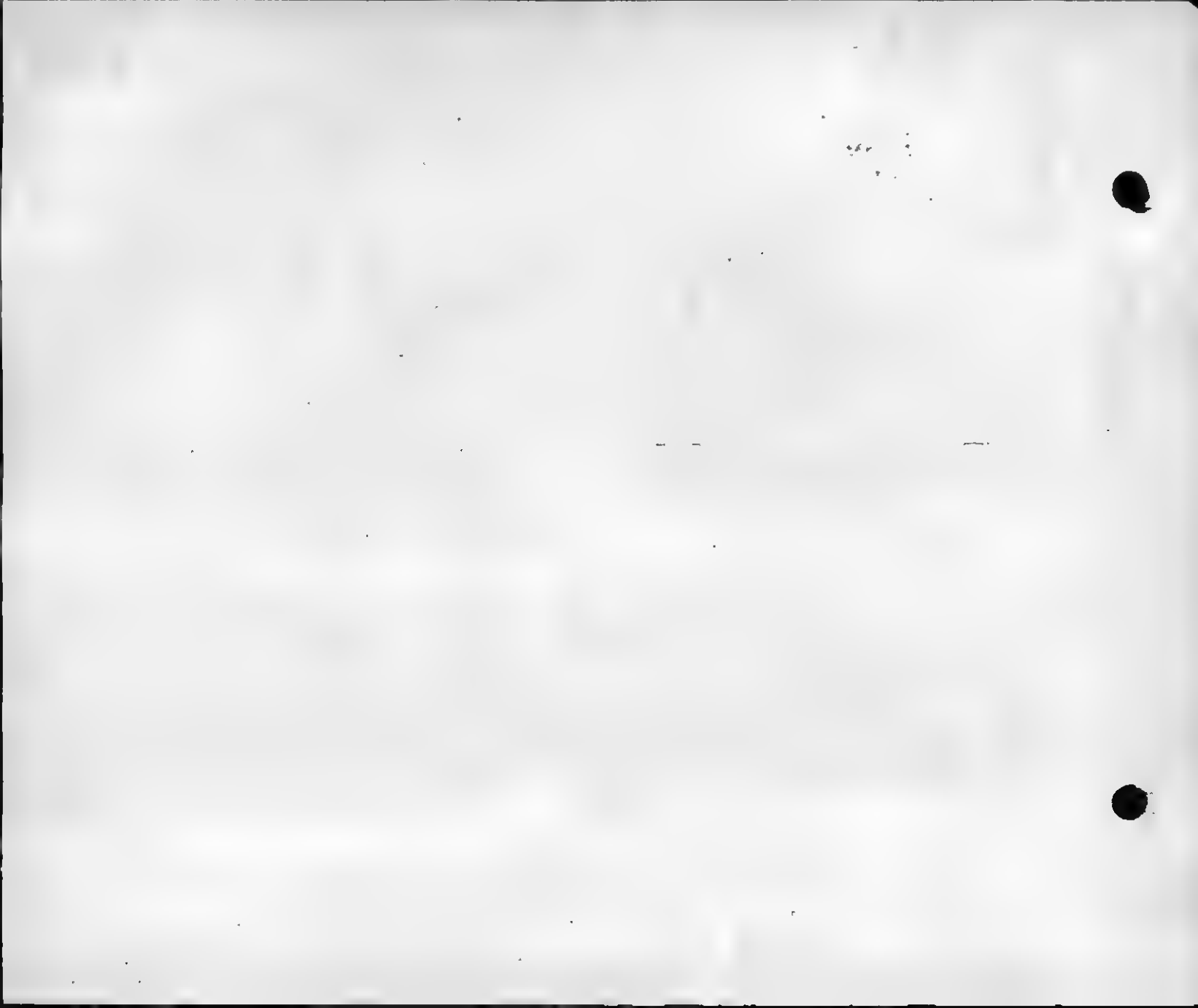
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04695

CERTIFICATE OF DEATH

Reg. Dist. No. 04696

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		d. STREET ADDRESS <b>2132 Oakland Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elinor M. Colison</b>		4. DATE OF DEATH Month Day Year <b>4/26/67 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1893</b>
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-36-6784</b>	
17. INFORMANT <b>Walter M. Colison</b>		Address <b>902 Essex Sq.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Acute &amp; Chronic Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <b>Failure of Arterio-Sclerotic Cardio-Vascular Disease</b> <b>2. Presence of Pulmonary Tuberculosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thromboplastin left old</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>10 yrs</b> <b>15 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/25/67</b> , 19 <b>67</b> , to <b>4/26/67</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>4/25/67</b> , 19 <b>67</b> , and that death occurred at <b>2:55 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W E McGillich M.D.</b>		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b>	
PHYSICIAN'S NAME (Type) <b>W E McGillich M.D.</b>		DATE SIGNED <b>4/28/67</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 29, 1967</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chometh</b>		ADDRESS <b>3617 Chestnut Ave.</b>	
24a. REC'D BY REGISTRAR <b>MAY 2 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 3 Film 615 2/11/67 KS

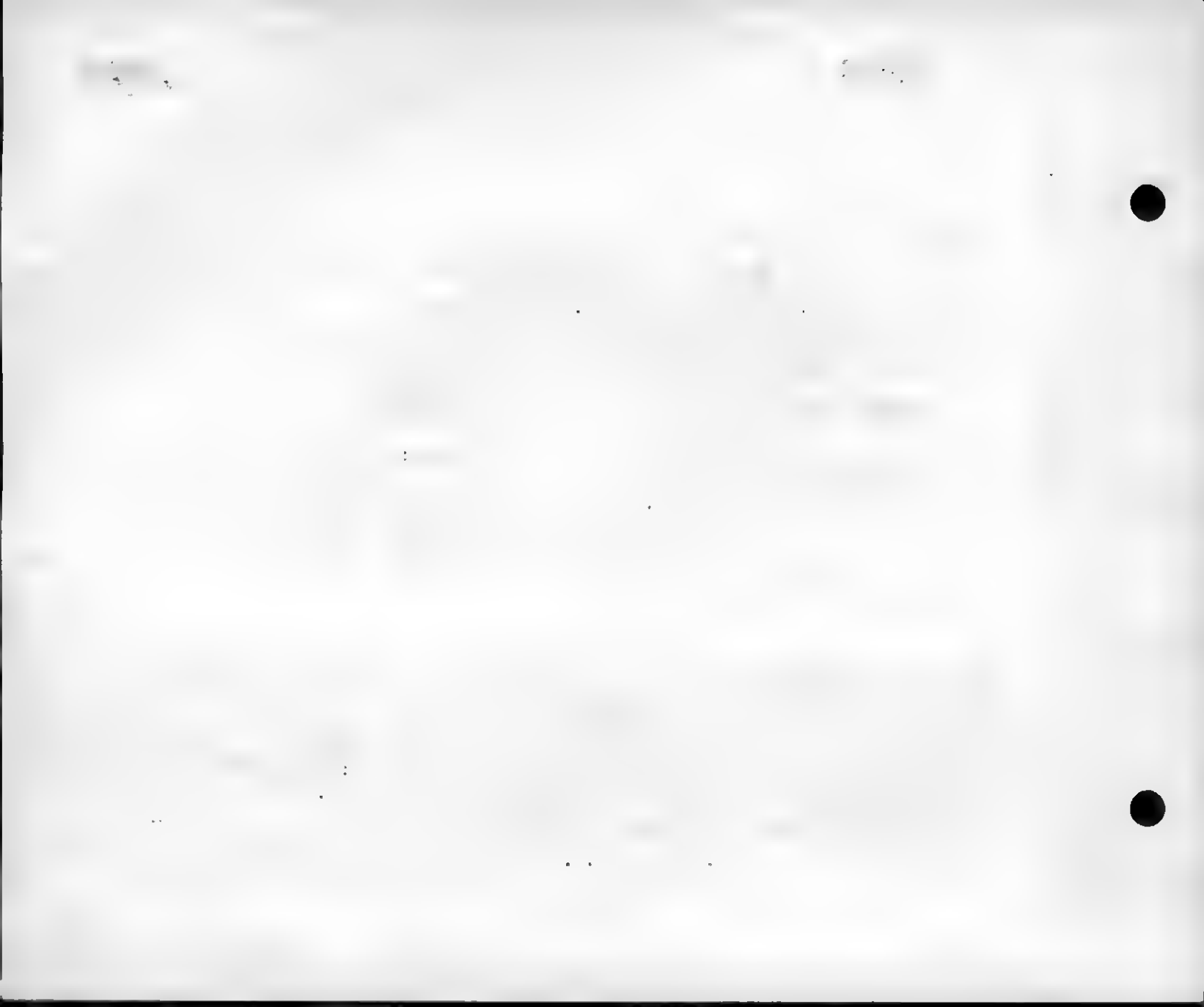
04696

CERTIFICATE OF DEATH

04688

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY in 1b <b>34yrlmth19dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>617 Madison Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Colavino</b> Last <b>Callabina</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>separated</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1899</b>	9. AGE (in years last birthday) <b>68</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>				13. FATHER'S NAME <b>Anthony Rizzo</b>			
14. MOTHER'S MAIDEN NAME <b>Cecelia</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Pneumonia Right</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 9</b> , 19 <b>67</b> to <b>April 28</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 28</b> , 19 <b>67</b> , and that death occurred at <b>6:35</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>				22b. DATE SIGNED <b>5-1-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				22e. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>5/4/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City or town) (County) (State) <b>WILMINGTON, DEL.</b>	
24. FUNERAL DIRECTOR <b>Robert J. Munk F.H.</b>				25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	
25c. ADDRESS <b>301 FREDERICK RD 21228</b>				25d. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

in E.B. Mac Nabb



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04697

04697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2.2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House On The Pines</u>				d. STREET ADDRESS <u>53 So. Carrollton Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Nola E. Colquith</u>		First Middle Last		4. DATE OF DEATH <u>4 / 29 / 1967</u>		Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 31 - 51</u>		9. AGE (In years last birthday) <u>66 yrs</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Edw. Frankline</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Doris Henderson</u> Address <u>226 Hollins Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Diabetes Mellitus</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-28-1967</u> to <u>4-29-1967</u> , that (I) (we) last saw the deceased alive on <u>4-28-1967</u> , and that death occurred at <u>3:55</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>				22b. DATE SIGNED <u>5/1/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>	
23d. LOCATION (City, town or county) <u>3310 Taylor Ave Md.</u>				23e. REC'D BY REGISTRAR <u>May 2 1967</u>		23f. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Curran &amp; Son Inc.</u>				24b. ADDRESS <u>12 Hollins St.</u>		24c. CITY, STATE, ZIP <u>23, Md.</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

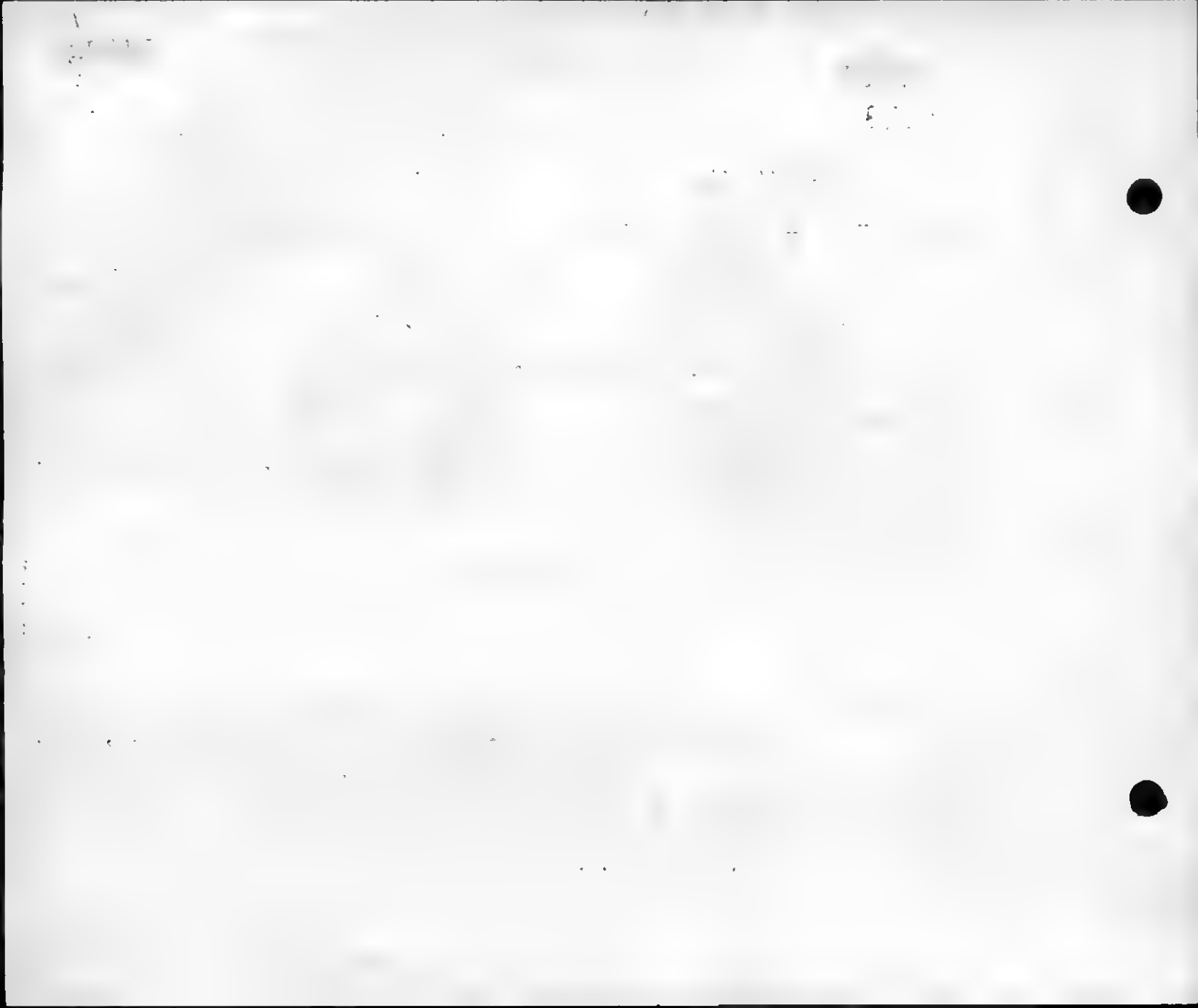
MATLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04698

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c LENGTH OF STAY IN 1b <b>1 day</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County General Hospital</b>			e STREET ADDRESS <b>2833 Riggs Avenue 21216</b>		
3 NAME OF DECEASED (Type or print) First Middle Last <b>JACKIE COVINGTON</b>			4 DATE OF DEATH Month Day Year <b>4 23 19 67</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/27/49</b>	9 AGE (in years last birthday) <b>17 yrs</b>	10 FUNDING YEAR Months Days Hours Min <b>1 1 0 0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>NO SPECIAL ONE</b>		11 BIRTHPLACE (State or foreign country) <b>N.C.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13 FATHER'S NAME <b>GRADY COVINGTON</b>		
14 MOTHER'S MAIDEN NAME <b>Dorothy Knight</b>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <b>NO</b>		
16 SOCIAL SECURITY NO <b>UNKNOWN</b>			17 INFORMANT <b>Dorothy COVINGTON 2833 Riggs Ave</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>782X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Stabbed in chest</b>			
20c TIME OF INJURY Month Day Year <b>7:45 p.m. 4 23 67</b>		20d NATURE OF INJURY Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, playground, etc) <b>Gwynn Oak Park</b>		
20f (City or town) <b>Baltimore</b>		20g (County) <b>Balto.</b>		20h (State) <b>Md.</b>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>			22. DATE SIGNED <b>4-24-67</b>		
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
23a BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/28/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Wt. Auburn</b>	
23d LOCATION (City or town) <b>Balto. Md.</b>		23e LOCATION (County) <b>Balto.</b>		23f LOCATION (State) <b>Md.</b>	
24 FUNERAL DIRECTOR <b>Wm. S. Chatman - 1701 N. Calhoun St</b>		25a REC'D BY REGISTRAR <b>APR 26 1967</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

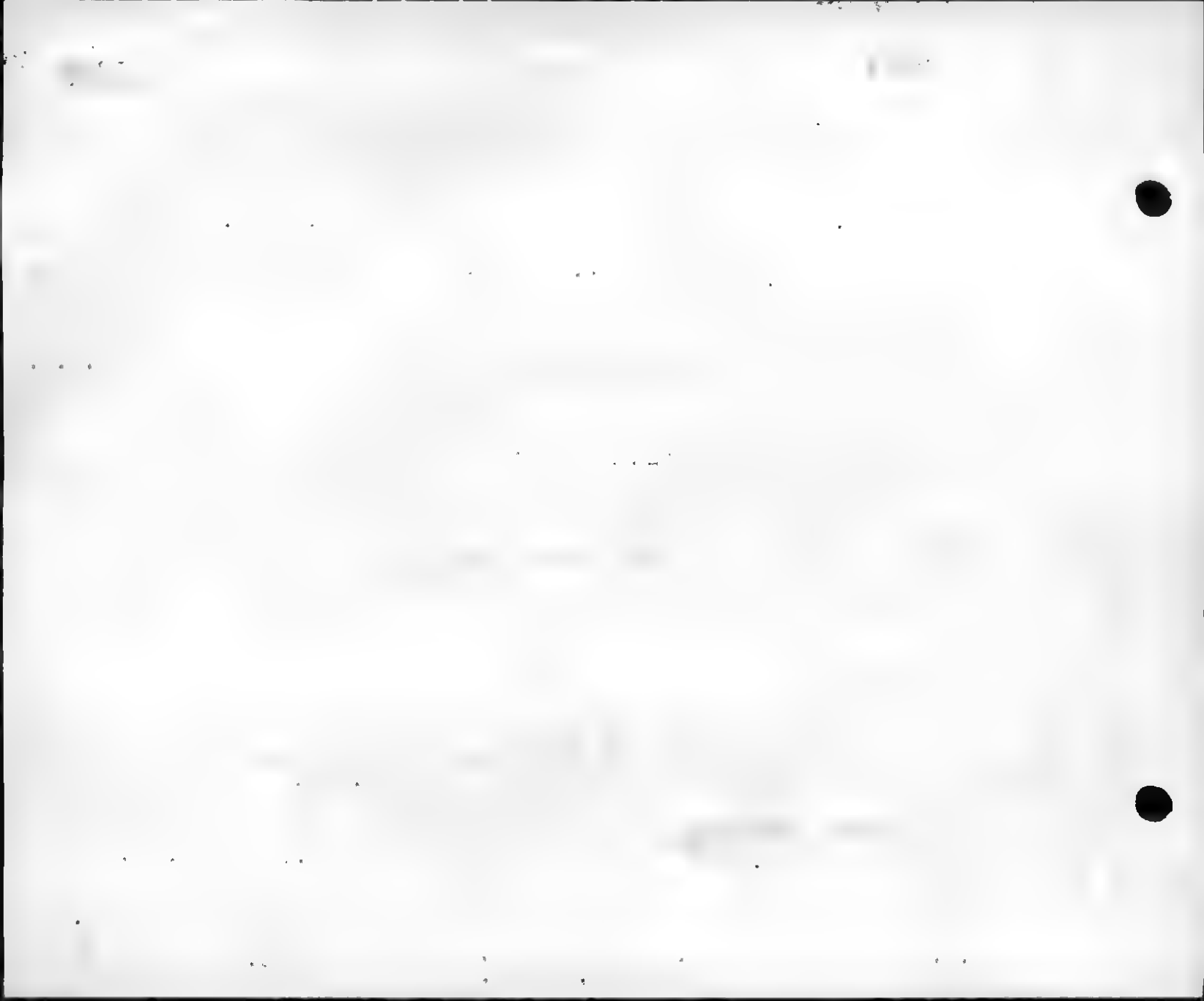
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04699

## CERTIFICATE OF DEATH

04699

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 'b' _____		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b> d. STREET ADDRESS <b>5628 Alhambra Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>J.</b> Last <b>Crogran</b>		4 DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 67</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/16/85</b>
9 AGE (In years last birthday) <b>81</b> yrs		10 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min _____	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Printer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Ireland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John Crogran</b>		14 MOTHER'S MAIDEN NAME <b>Mary Neary</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>213-01-6766</b>	
17 INFORMANT <b>Daniel Crogran</b>		Address <b>(Same)</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiac Arrhythmia</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>March 25, 1967</b> , to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>4:40 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>April 3 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez</b>		22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/6/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City or Town) <b>Baltimore, Md.</b> (County) _____ (State) _____
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 4 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

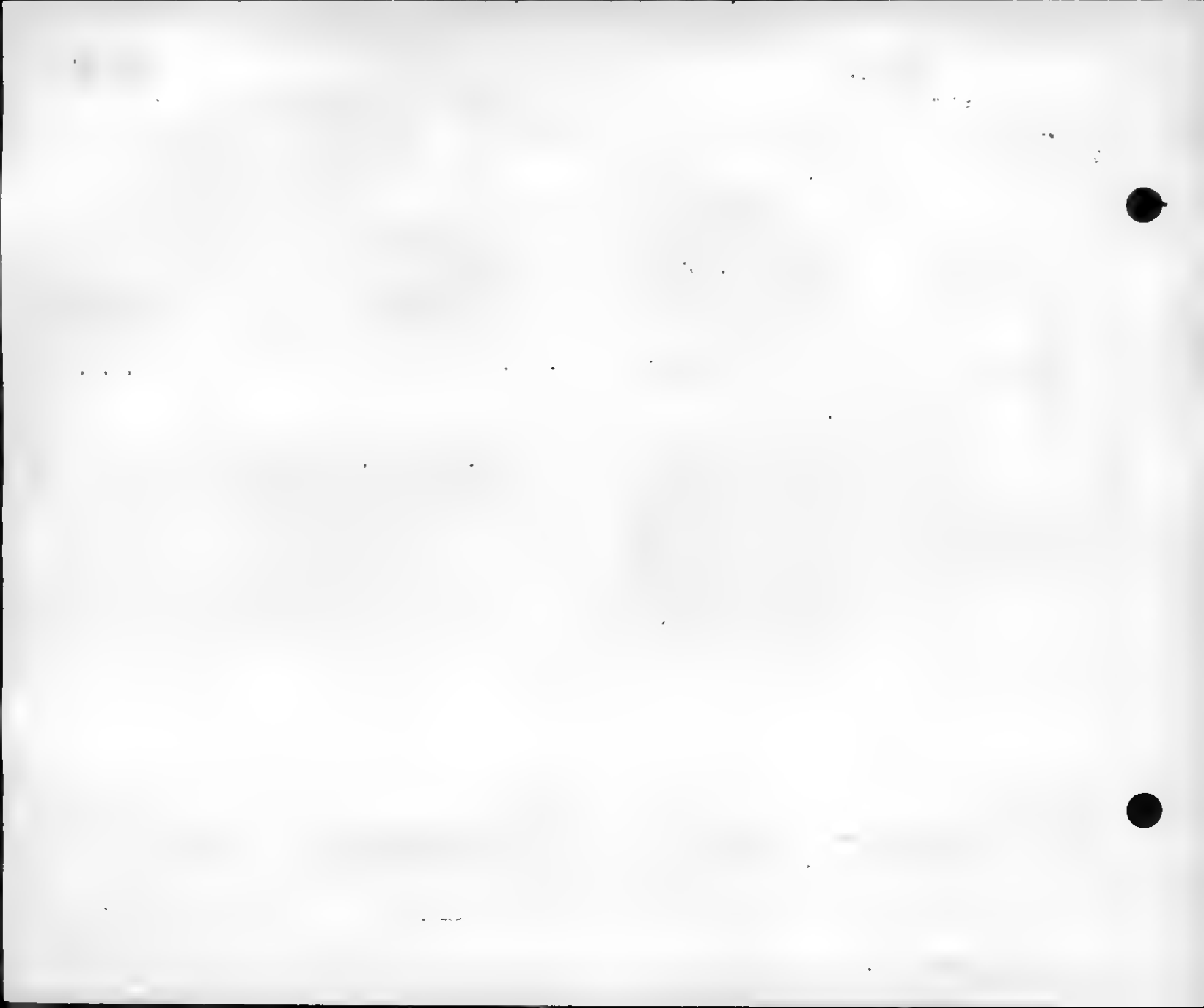
04700

04700

1. PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1035 Ingleside Avenue</b>		d STREET ADDRESS <b>1035 Ingleside Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN T. DALE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-10-1900</b>
9 AGE (In years last birthday) <b>66</b> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11b KIND OF BUSINESS OR INDUSTRY <b>Bastian Bros. Co.</b>	
12 BIRTHPLACE (County & State or foreign country) <b>Alabama</b>		13 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14 FATHER'S NAME <b>William N. Dale</b>		15 MOTHER'S MAIDEN NAME <b>Unknown</b>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17 SOCIAL SECURITY NO. <b>203-09-5818</b>	
18 INFORMANT <b>Mrs. Viola S. Dale</b>		Address <b>1035 Ingleside Avenue</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Esophageal Cancer</b> DUE TO (b) <b>Cardiac Arrest</b> DUE TO (c) <b>Stroke</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia due to hyperkalemia, hyperkalemia, ...</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>4/8</b> , 19 <b>67</b> , to <b>4/8</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>4/8</b> , 19 <b>67</b> , and that death occurred at <b>4 A</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>Dr. Max Miller</b>		22b DATE SIGNED <b>4/8/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Dr. Max Miller</b>		22d ADDRESS <b>1047 Ingleside Avenue</b>	
23a BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>4-11-1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a REC'D BY REGISTRAR <b>APR 10 1967</b>	
ADDRESS <b>4107 Wilkens Avenue</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

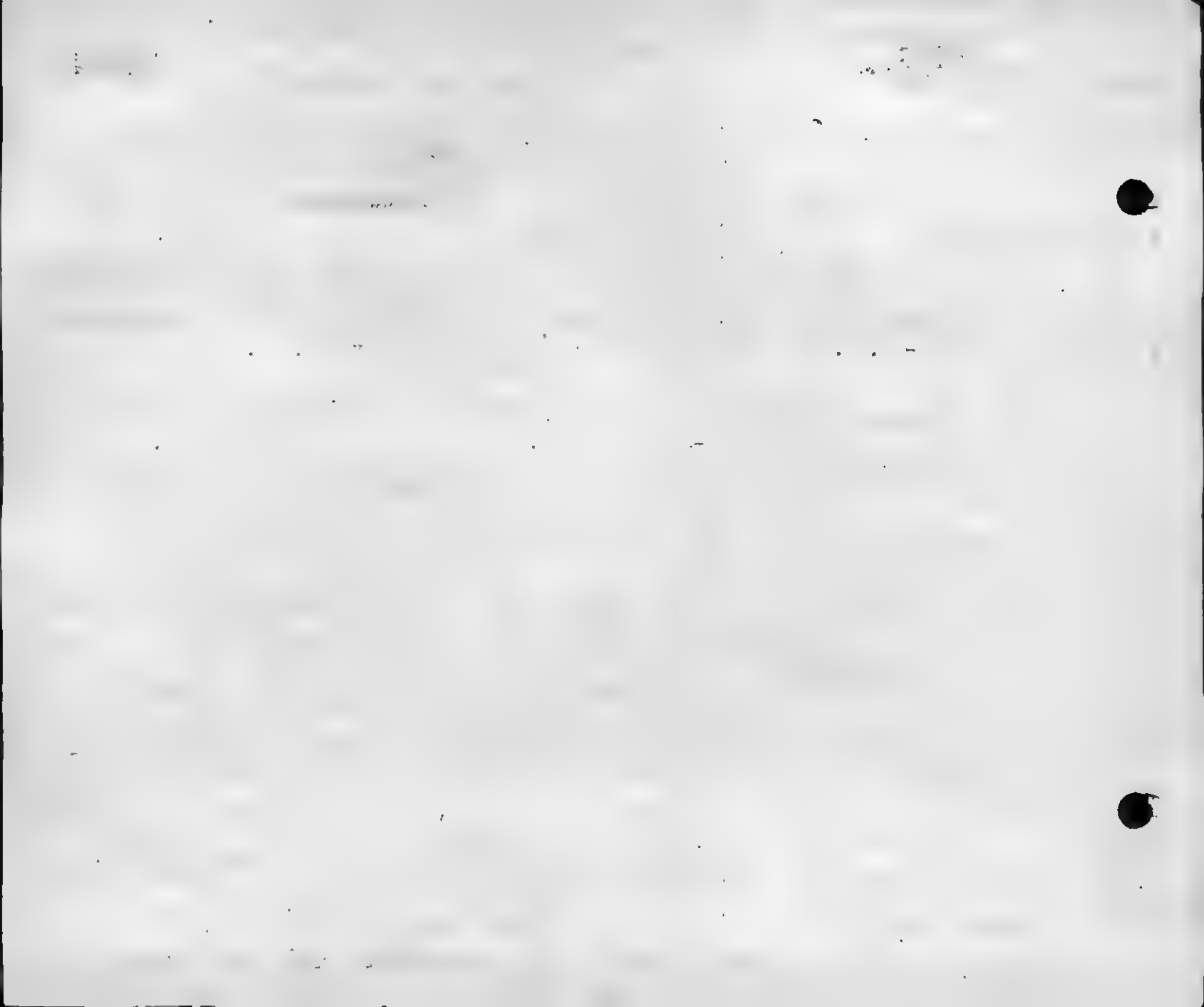
04701

## CERTIFICATE OF DEATH

04701

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>305 Alabama Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Franklin Davis</b>		4. DATE OF DEATH Month Day Year <b>April 7, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1890</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - V. P.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Davis Construction</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Mitchellville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph Davis</b>		14. MOTHER'S MAIDEN NAME <b>Clara E. Parlett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-4845</b>	
17. INFORMANT <b>Mr. Joseph Davis</b>		Address <b>305 Alabama Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Parkinson's Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 17, 1965</b> to <b>April 7, 1967</b> that (I) <b>(was)</b> last saw the deceased alive on <b>March 10, 1967</b> , and that death occurred at <b>7:45 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Martin E. Singewald</b>		22b. DATE SIGNED <b>4/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN E. SINGEWALD</b>		22d. ADDRESS <b>116 Chase St Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4/10/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harleigh Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Camden, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Johnson &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Chas. J. Judge</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04702

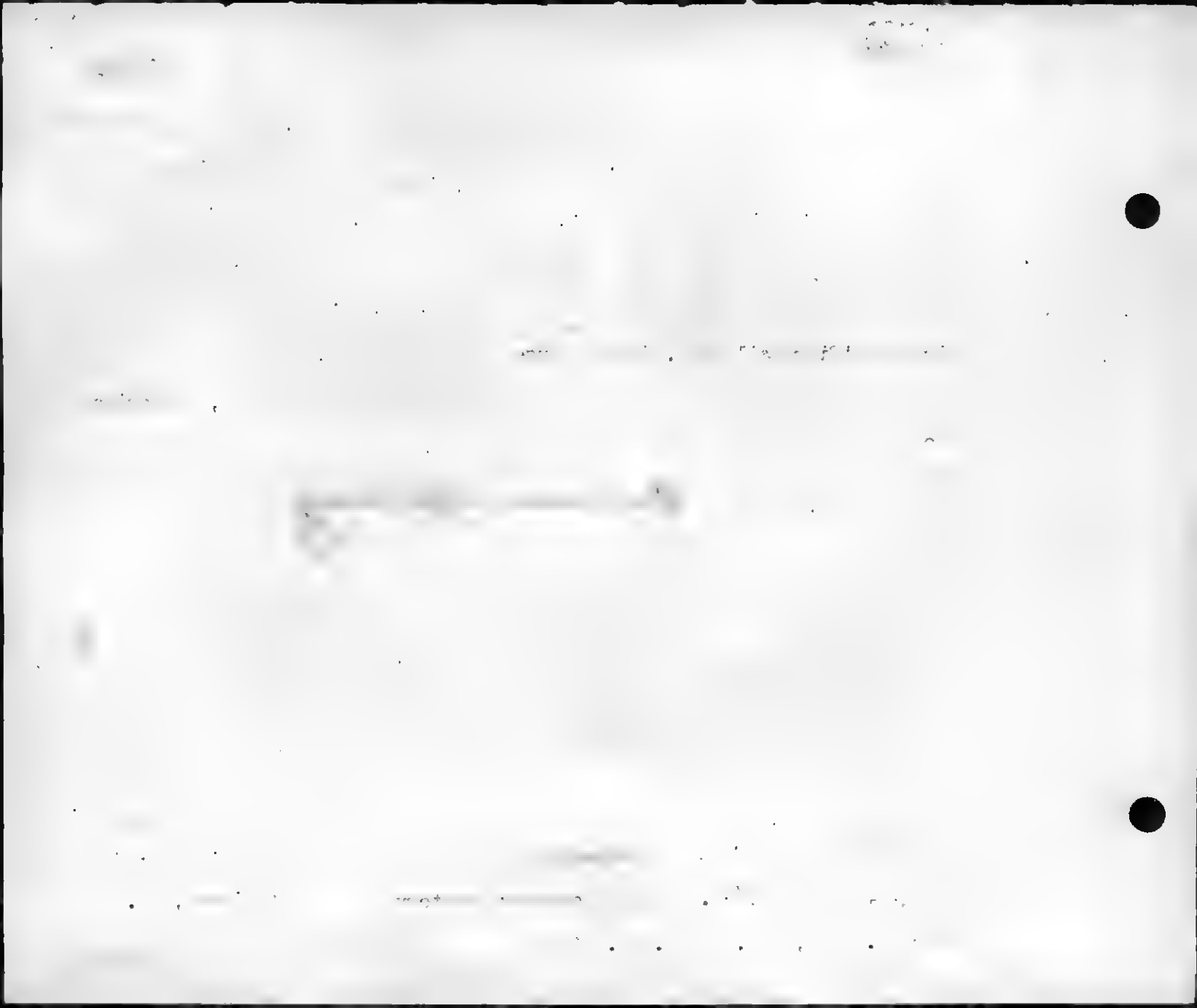
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04702

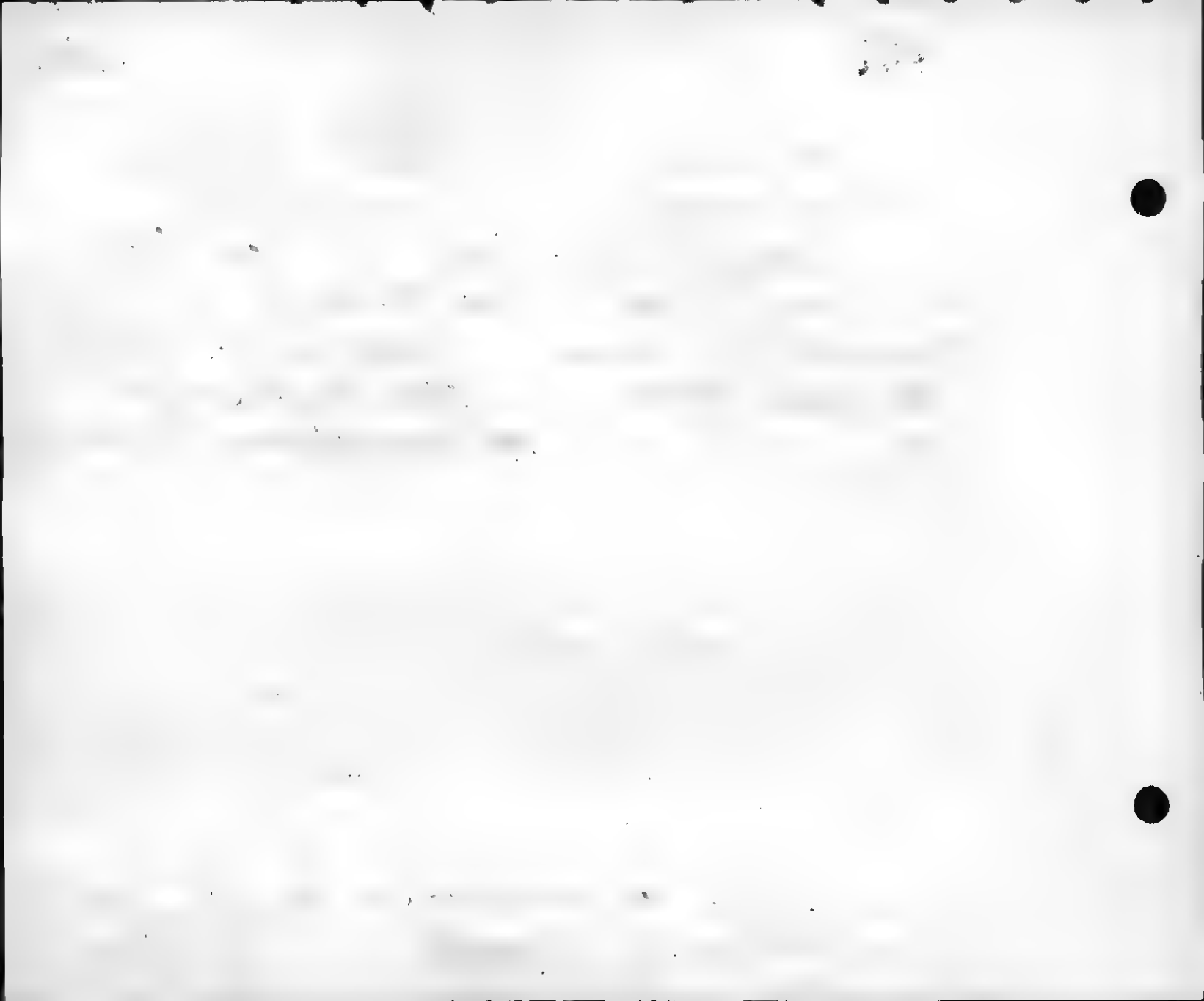
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN ID <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 21214</b>		d. STREET ADDRESS <b>5807 A WILLOWTON AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTRE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH G DAVIS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>23</b> Year <b>1967</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU.</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/04/1897</b>		9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Verifier Mail Dept. Custom House</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MONTCLARE, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>KEPLINGER, Catherine</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 097 053</b>		17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma right lung</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-8</b> , 19 <b>67</b> , to <b>4-23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-23</b> , 19 <b>67</b> , and that death occurred at <b>9:25</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>M. Isabelle Mac Gregor</b>				22b. DATE SIGNED <b>4-23-67</b>		22c. PHYSICIAN'S NAME (Type) <b>E. HUNTER WILSON</b>	
22d. ADDRESS <b>G.B.M.C. N. Charles St.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>4/26/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Young</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04703											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Freeland Rd.</u>						d. STREET ADDRESS <u>Freeland Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Loma</u> Middle <u>Viola</u> Last <u>Day</u>						4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1882</u>		9. AGE (in years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Krout</u>						14. MOTHER'S MAIDEN NAME <u>Ella Waltemeyer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Greta Midwig, Freeland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>3-13, 1967</u> to <u>4-5, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-24, 1967</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Donald L. Bortner</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-6-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. BORTNER</u>						22d. ADDRESS <u>NEW FREEDOM, PA.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4/8/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove E. U. B. Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Rayville, Md.</u>		
24. FUNERAL DIRECTOR <u>St. Jacob Hartenstein, New Freedom, Pa.</u>						25a. REC'D BY REGISTRAR <u>APR 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

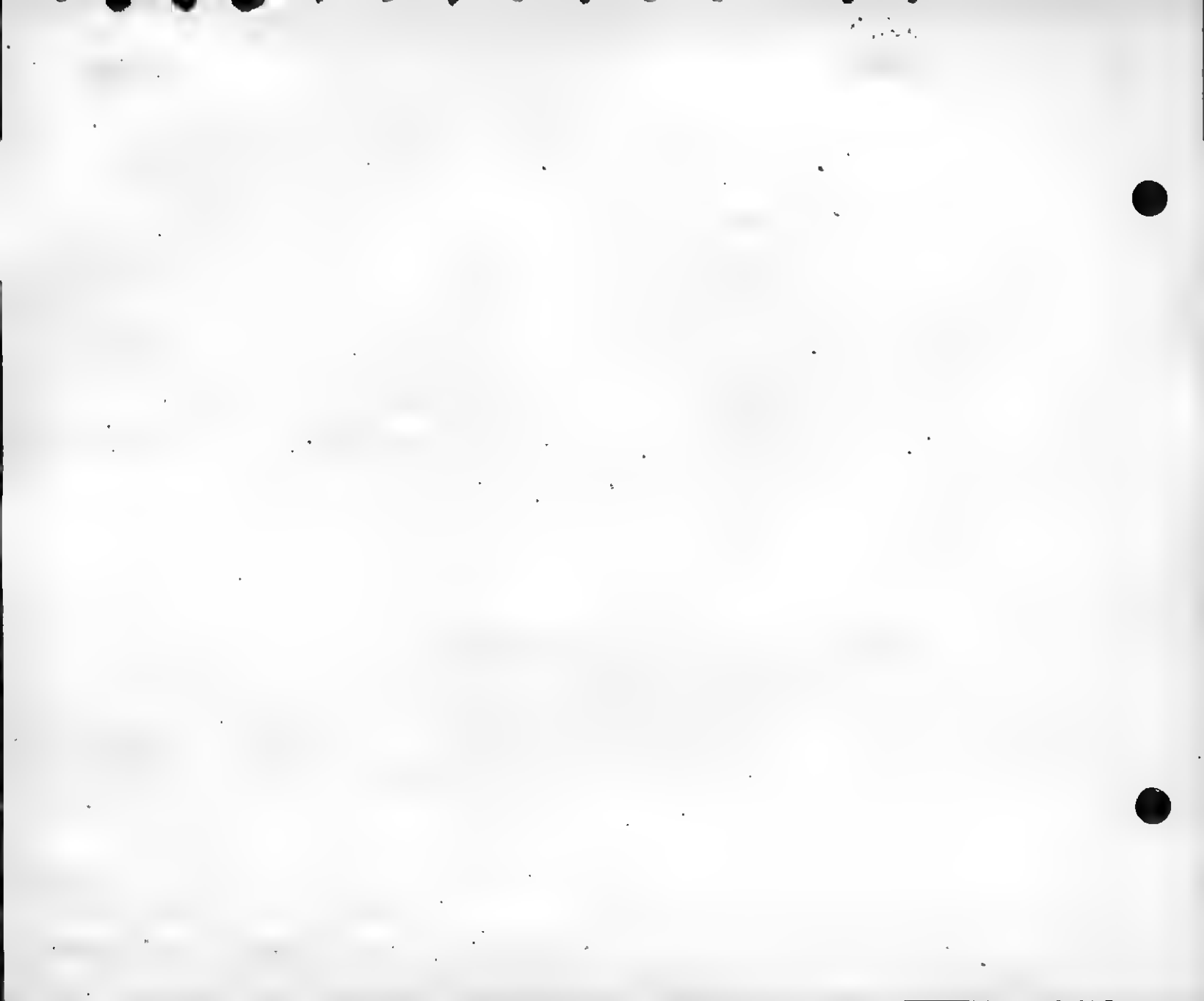




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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04704						04704					
1. PLACE OF DEATH a. COUNTY <u>Balto. -</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural White Hall 4 mo. -</u> c. LENGTH OF STAY IN 1b <u>4 mo. -</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Vernon Rd. -</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto. -</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland -</u> d. STREET ADDRESS <u>Freeland Rd. -</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Welzetta S. Day</u> First Middle Last						4. DATE OF DEATH <u>4 / 23 1967</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 7, 1882</u>		9. AGE (In years) <u>85</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home maker</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home maker</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>own home. -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md. - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. E. Bahn -</u>						14. MOTHER'S MAIDEN NAME <u>Carrie Smith -</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>218-14-7750</u>		17. INFORMANT <u>Mrs. Pearce Morris White Hall, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C. S. C. V disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4221</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>4-23, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-22, 1967</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>A. M. France</u> M.D.						22b. DATE SIGNED <u>4/23/67</u>		22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE M.D.</u>		22d. ADDRESS <u>Parkton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>April 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery White Hall, Md.</u>		23d. LOCATION (City, town or county) (State)		23e. REG'D BY REGISTRAR	
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>				24b. ADDRESS <u>New Freedom, Pa.</u>		24c. DATE <u>APR 27 1967</u>		24d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		24e. ADDRESS	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE HEALTH DEPARTMENT

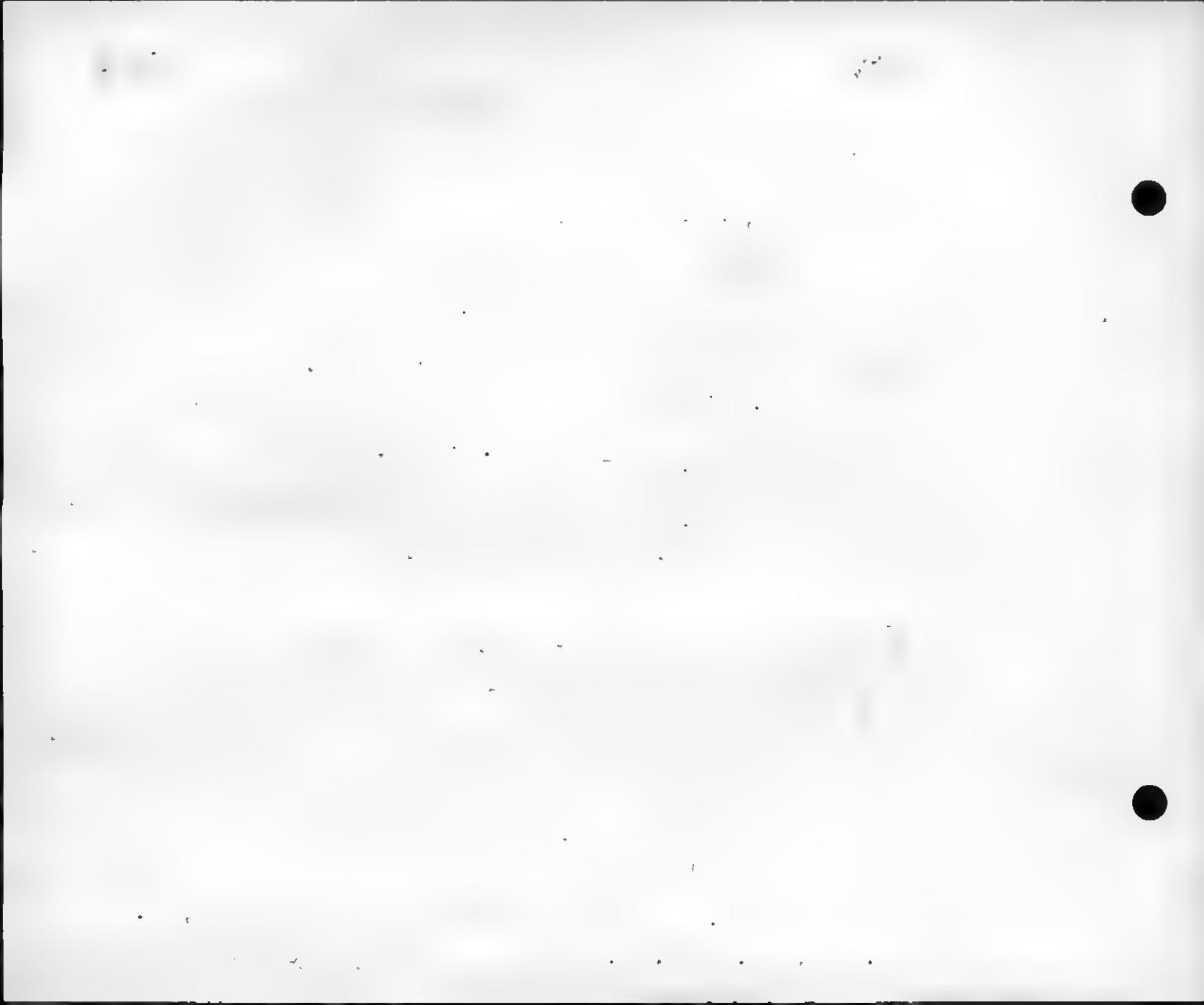
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04705

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to, give street address) <b>St. Joseph Hospital, 7620 York Road, 21204</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3208 Echodale Avenue #21214</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>GODFREY</b> Last <b>DEININGER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-01</b>	9. AGE (In years last birthday) <b>66</b>	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maryland State Roads Commission</b>			10b. KIND OF BUSINESS OR IND. STRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John M. Deininger</b>				
14. MOTHER'S MAIDEN NAME <b>Meta Kandler</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO <b>216-09-1255</b>			17. INFORMANT <b>Mrs. Mabel E. Deininger</b> Address <b>(Same)</b>				
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>612X</b> DUE TO <b>Coronary Artery Disease and Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Coronary Disease for Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Arteriosclerosis of the Coronary Heart Disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>No</b>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Hospital</b>		20f. (City or town) <b>Towson</b> (County) <b>Baltimore</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22. DATE SIGNED <b>4/5/67</b>	
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23c. BURIAL (CREMATION REMOVAL) (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/10/67</b>	23. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore, Md.</b> (County) (State)			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

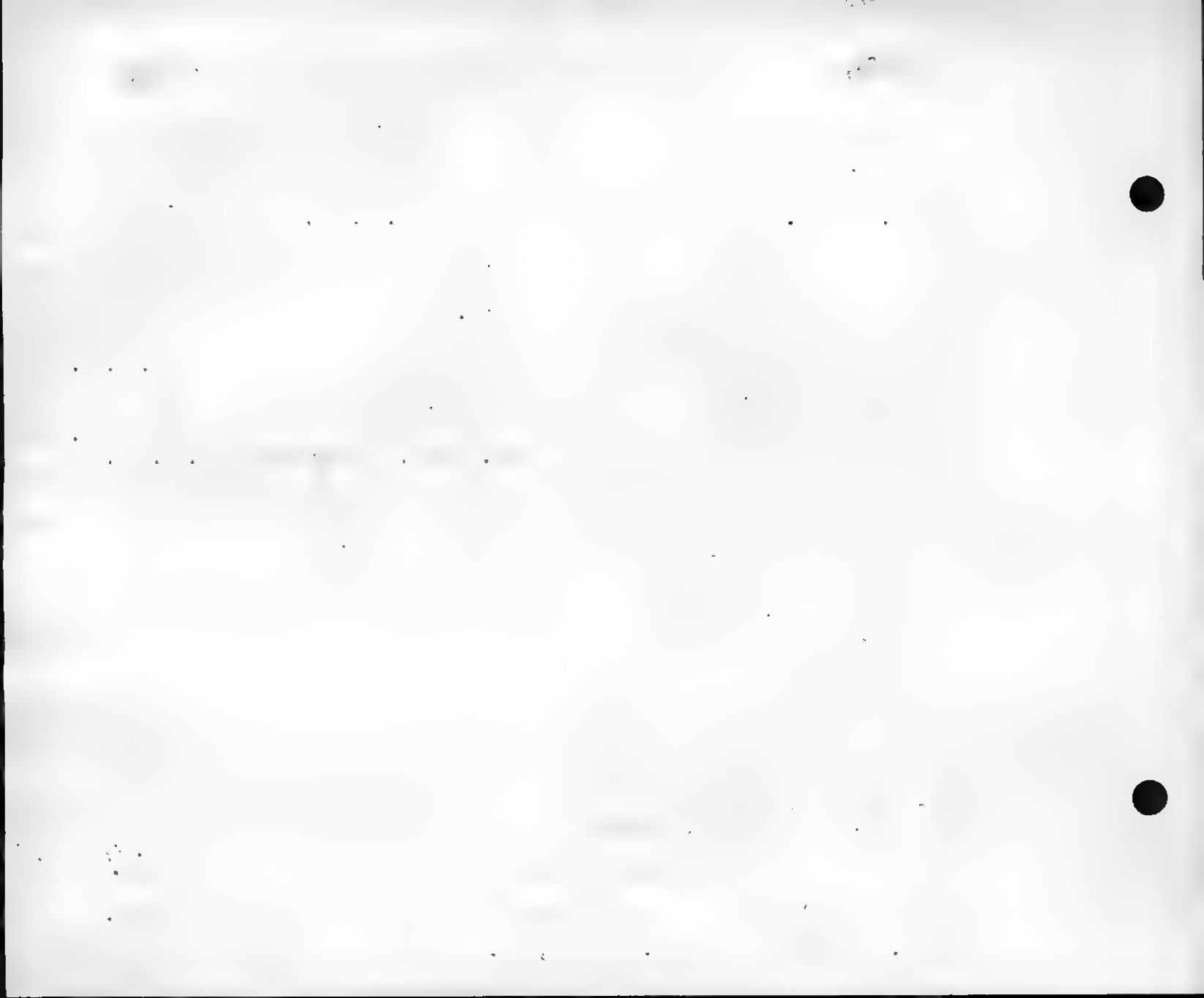
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04706

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Edgemere</b>			c. LENGTH OF STAY N 1b <b>One Year</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>169 Ave. A, Rt. 10</b>				d. STREET ADDRESS <b>169 Ave. A, Rt. 10</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Josephine</b>		First Middle Last <b>Del Tergo</b>		4 DATE OF DEATH <b>April 21 19 67</b>		Month Day Year	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan. 20, 1889</b>	9 AGE (in years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Italy</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Sebastian Vincenti</b>			14. MOTHER'S MAIDEN NAME <b>Mary Anna Carco</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>011 14 0240</b>		17 INFORMANT (Daughter) <b>Mrs. Mary A. Loncala, 169 Ave. A. Rt. 10</b>		Address <b>Edgemere, Md. 19</b>	
18 CAUSE OF DEATH (Enter only one cause per (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>arterosclerotic Heart Disease</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypothyroidism</b>						9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>pm 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>THEO. C. PATTERSON</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>4/21/67</b>	
EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>105 Main St. Dundalk, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Malden, Mass.</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a. RECEIVED BY REGISTRAR <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

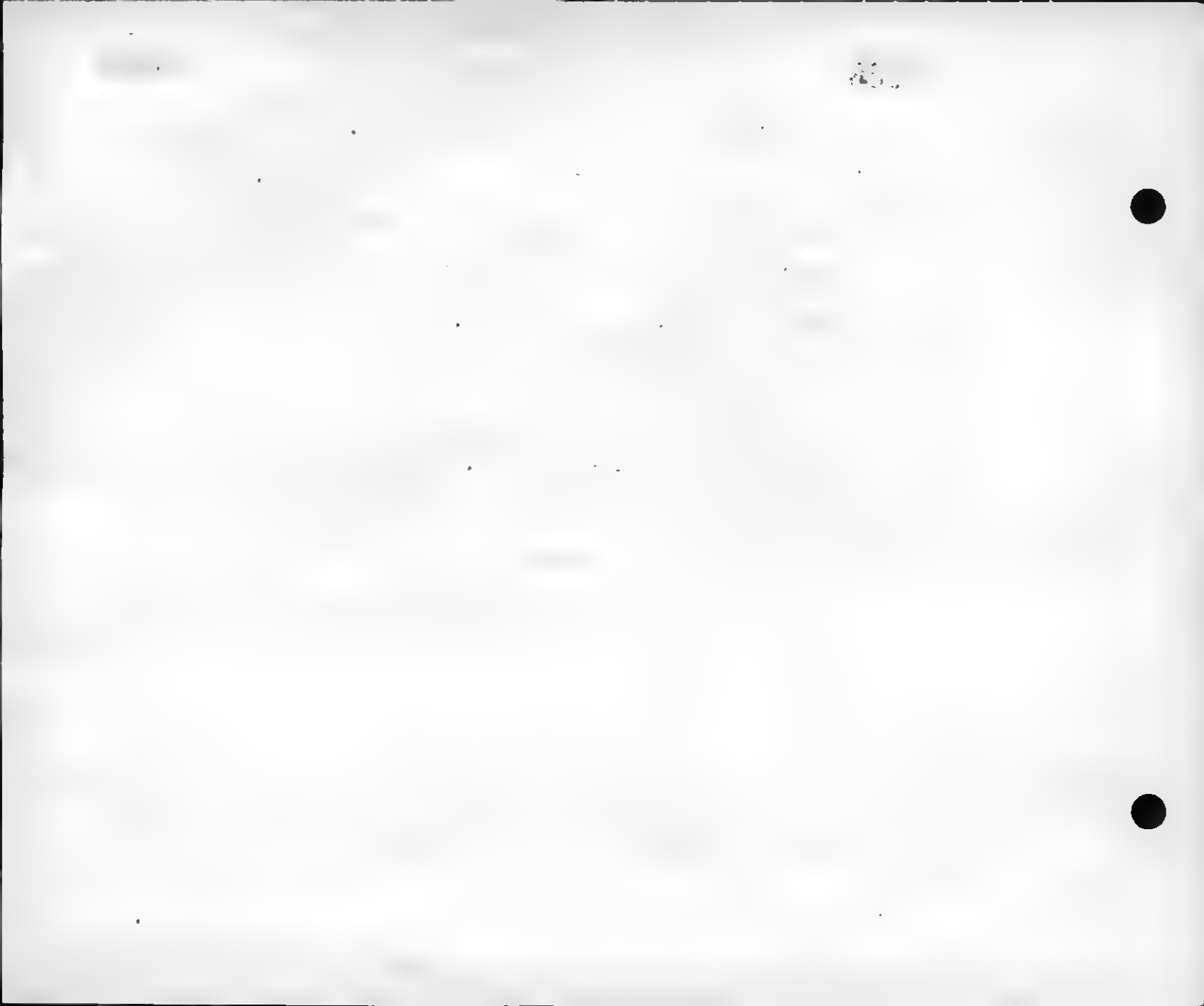
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04707

CERTIFICATE OF DEATH

04707

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN TB <u>5 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 3, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Robbs Nursing Home</u>				d. STREET ADDRESS <u>309 Church Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josefa Maria Devilbiss</u>				4. DATE OF DEATH Month Day Year <u>April 3, 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1884</u>	9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Hulshof</u>				14. MOTHER'S MAIDEN NAME <u>Mueller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-5958</u>		17. INFORMANT Address <u>MD.</u> <u>Mrs. Dorothy Grinnel, 309 Church Lane, Pikesville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lb breast with metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If other, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 1962, to <u>Apr 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 5, 1967</u> , and that death occurred at <u>3:49</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Paul H Royse</u>				22b. DATE SIGNED <u>Apr 10, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>	
23a. BIRTH, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>New Windsor, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank J. Stenell, Pikesville, Md.</u>				25. REC'D BY REGISTRAR <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	





1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04708

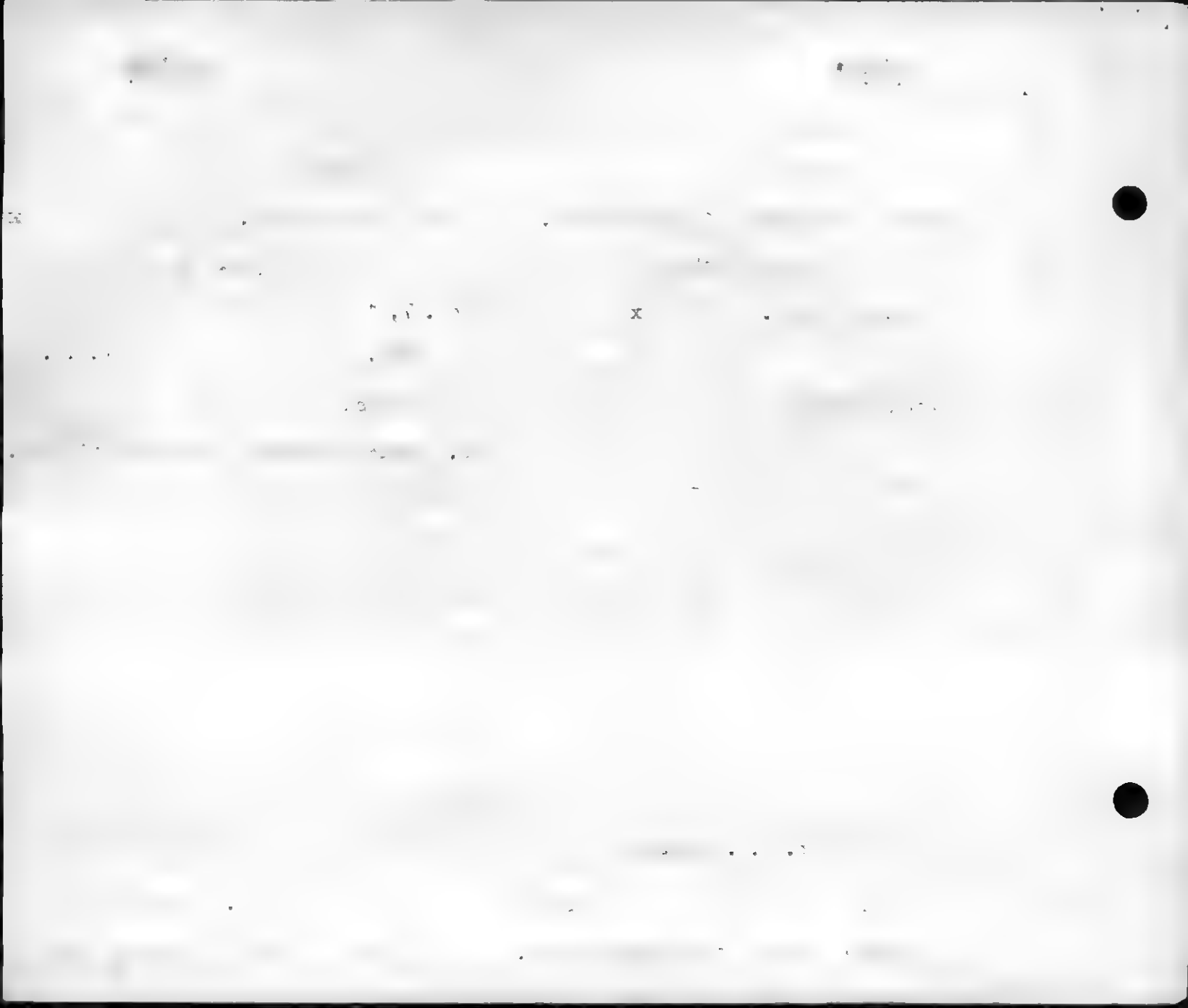
CERTIFICATE OF DEATH

04708

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House In the Pines 16 Fusting Ave.</b>		e. STREET ADDRESS <b>4401 Flowerton Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>Daisy Dittell</b>		4 DATE OF DEATH Month <b>April</b> Day <b>28</b> , Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1875</b>
9 AGE (In years last birthday) <b>91 yrs</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>12</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>Penna.</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hush</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Stanley Magersupp</b>		Address <b>#21093 2315 Ravenview Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Hypostatic Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypostatic Cardio-Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>12 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured Left Hip 6/12/66</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> , 19 <b>54</b> , to <b>4/28</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>4/27</b> , 19 <b>67</b> , and that death occurred at <b>3:51 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>E. W. Johnson</b>		22b. DATE SIGNED <b>4/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. E.W. Johnson</b>		22d. ADDRESS <b>3437 Edmondson Ave. Baltimore Md 21229</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-1-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Maryland</b>	
24. FUNERAL DIRECTOR <b>Witzke &amp; Sons 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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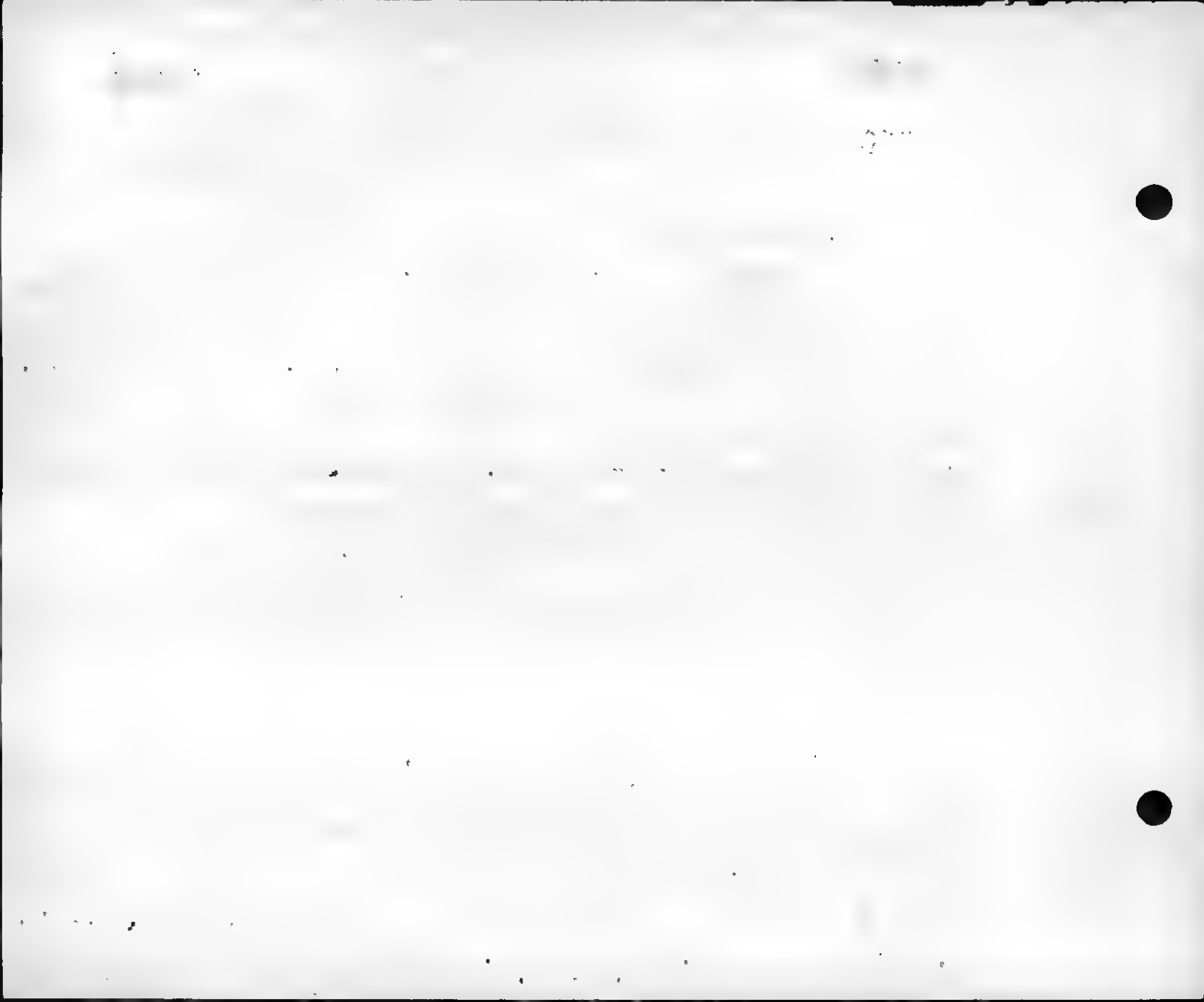
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04703

CERTIFICATE OF DEATH

04709

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1029 Upnor Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>H.</b> Last <b>Duckworth Sr.</b>		4 DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-25-12</b>
9 AGE (In years last birthday) <b>54</b> yrs		10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Small Loan Examiner - State of Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>State of Maryland</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Duckworth</b>	
14. MOTHER'S MAIDEN NAME <b>Agnes Holmes</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>165-03-2948</b>		17 INFORMANT <b>Mrs. Gilverta M. Duckworth (Same)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive gastro-intestinal hemorrhage</b> DUE TO (b) <b>hemorrhagic hypertrophic gastritis.</b> (c) <b>Post-operative Exploratory Laparotomy pseudo-cyst of pancreas.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MED. CA. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>4</b> (this hospital) attended the deceased from <b>March 29, 1967</b> , to <b>April 11, 1967</b> , that <b>0</b> (we) last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>6:05 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		22b. DATE SIGNED <b>April 11, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	23b. DATE THEREOF <b>4/14/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co., Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04710

CERTIFICATE OF DEATH

04710

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>3521 MILLVALE ROAD</b>				e. STREET ADDRESS <b>3521 MILLVALE ROAD</b>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>EDELBERG</b> Last				4. DATE OF DEATH <b>APRIL 21, 1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours M.n.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REPAIR</b>		11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ISAAC EDELBERG</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>MRS. ANNA EDELBERG, 3521 MILLVALE ROAD #7</b>			
18. CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> 4021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <b>Arteriosclerosis C.C.D.</b> DUE TO (c)						INTERVA. BETWEEN ONSET AND DEATH <b>4 yrs 11 mos 31</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <b>July 19, 51</b> to <b>21 April 1967</b> that (I) (we) last saw the deceased alive on <b>April 19, 67</b> , and that death occurred at <b>7:10 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>DR. JOSEPH GROSS</b> M.D.				22b. DATE SIGNED <b>4-21-67</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. JOSEPH GROSS</b>	
22d. ADDRESS <b>6911 PARK HEIGHTS AVENUE</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>		23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>				25a. REC'D BY REGISTRAR <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04711

CERTIFICATE OF DEATH

04711

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Dundalk</b>			c. LENGTH OF STAY IN 1b <b>20 yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore City Hospital 9 Dundalk Ave.</b>				d. STREET ADDRESS <b>1818 Tyler Rd</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Edwards</b>				4. DATE DEATH Month Day Year <b>4 25 19 67</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-31-1921</b>	
9. AGE (In years lost birthday) <b>45</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wireton W, Va</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Anthony Szczech</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Puskwicz</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <b>212416-4442</b>		17. INFORMANT Address <b>Hubert Edwards 1818 Tyler Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 9, 1967</b> , to <b>April 25, 1967</b> that (I) (we) last saw the deceased alive on <b>April 25, 1967</b> , and that death occurred at <b>7:00 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Benigno R. Lazaro</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>BENIGNO R. LAZARO</b>	
22d. ADDRESS <b>59 Dundalk Ave. Balt. Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-29-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Dabrowski 1005 Dundalk Avenue</b>				25. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

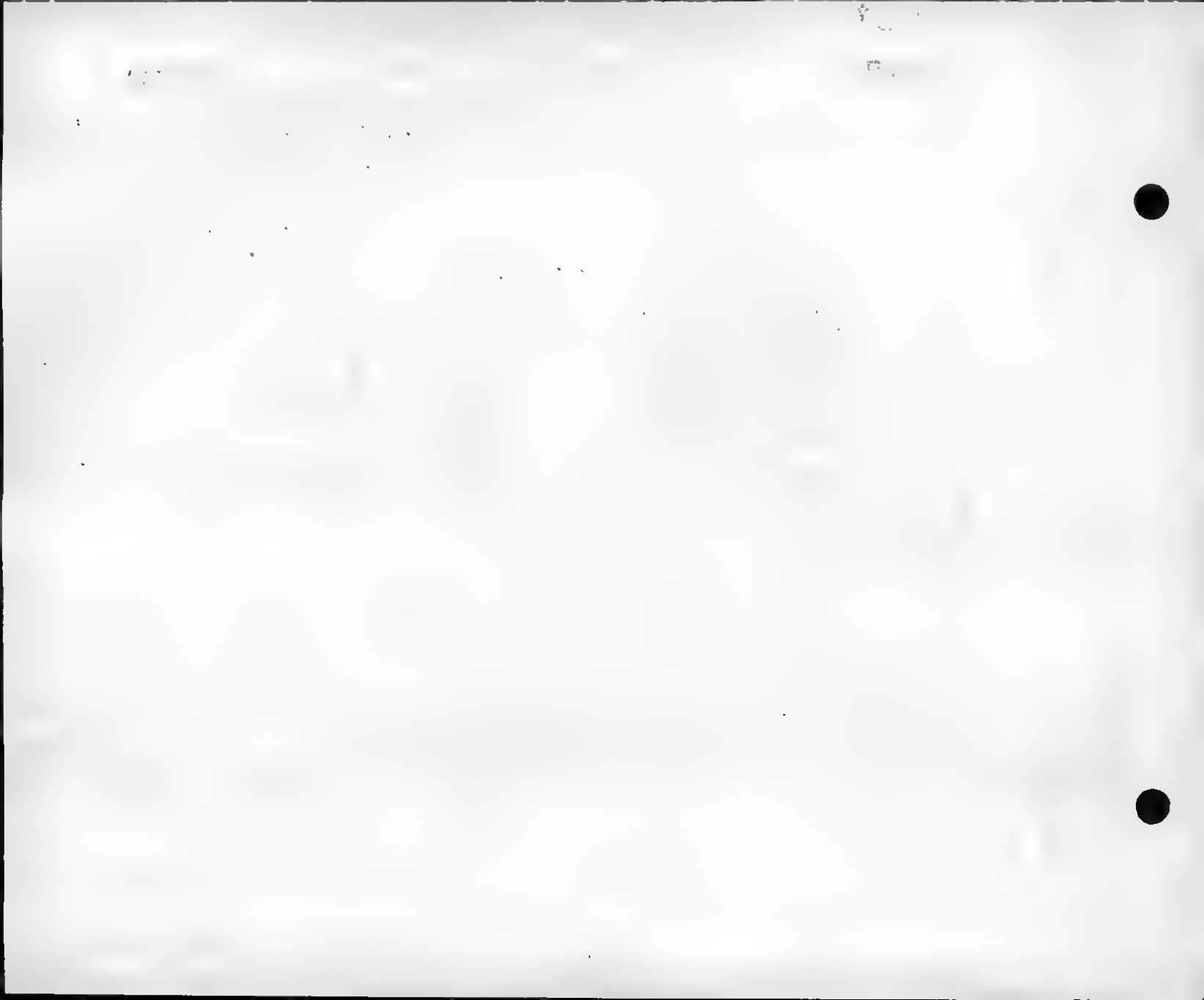
04712

## CERTIFICATE OF DEATH

04712

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

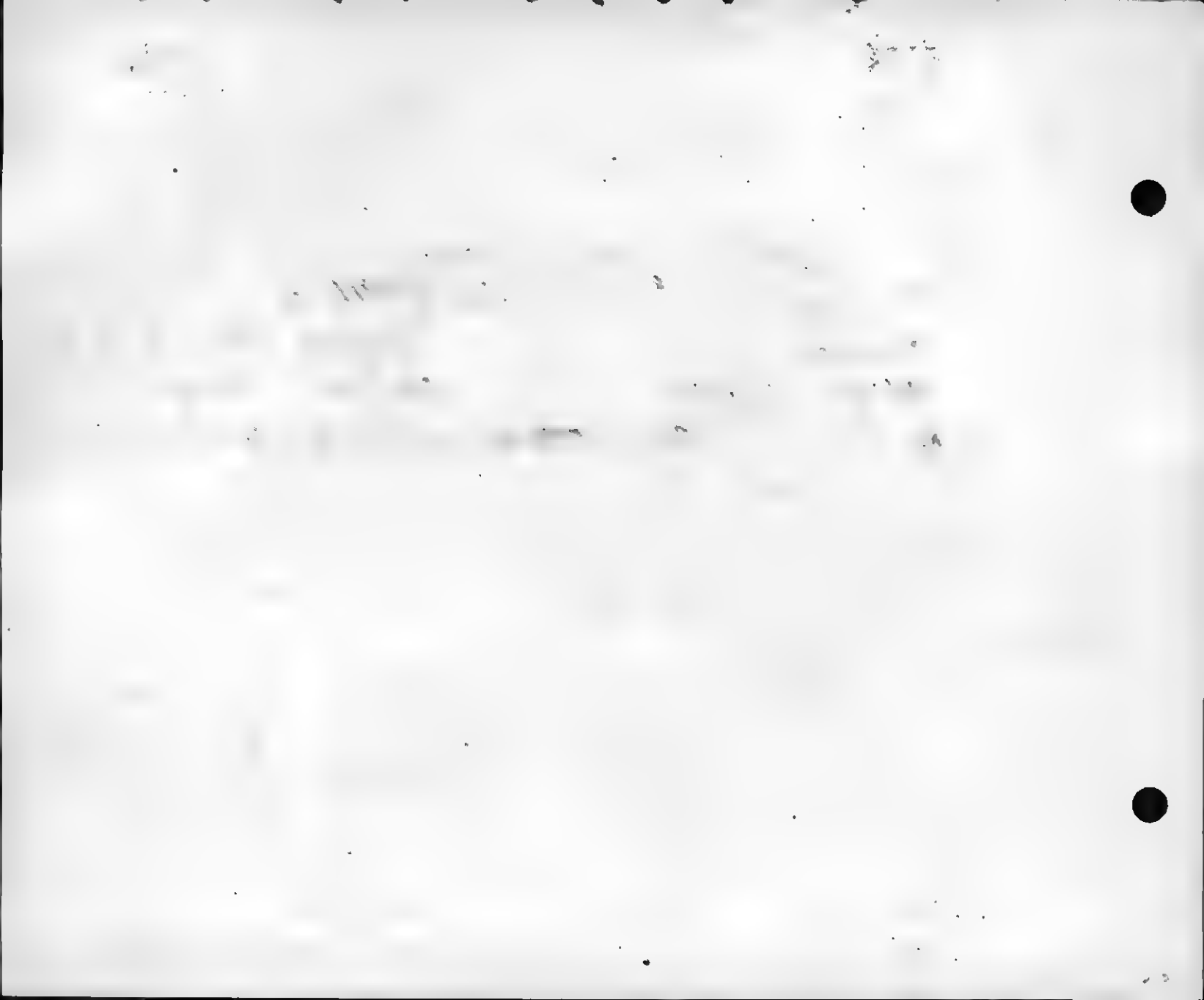
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Towson Convalescent Home</u>				d. STREET ADDRESS <u>520 Morris Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Ellen R. Elliott</u>				4. DATE OF DEATH <u>Apr. 12</u> Month <u>5</u> Day <u>19</u> Year <u>67</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Wh. sk</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8, 1881</u>	
9 AGE (In years lost birthday) <u>85</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13 FATHER'S NAME <u>John W. Shepperd</u>				14. MOTHER'S MAIDEN NAME <u>Ida Bacon</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>216-466611</u>		17 INFORMANT <u>Virginia Einstein</u>		Address <u>4504 Mandene Rd Balto. 29 Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A.S.C.V. disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> , to <u>4/8</u> , 19 <u>67</u> , that (I) <del>was</del> lost saw the deceased alive on <u>3/27</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>G. M. France</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				22d. ADDRESS <u>PARKTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Methodist Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Brooks</u>				ADDRESS <u>Towson Md</u>		25a. REC'D. BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>APR 12 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>04713</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>04713</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>						c. LENGTH OF STAY IN 1b <u>4 yrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wiseburg Rd.</u>						d. STREET ADDRESS <u>Wiseburg Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Clyde M. Ensor</u>						4. DATE OF DEATH <u>Apr 2</u> 1967					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1911</u>		9. AGE (in years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sparks, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alex Ensor</u>						14. MOTHER'S MAIDEN NAME <u>Hester Mays</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>212-03-5298</u>		17. INFORMANT <u>Melva F. Ensor, White Hall, Md.</u> Address <u></u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's Disease</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>APR 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APR 1</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>A. H. France</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>APR 2</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. H. FRANCE</u>						22d. ADDRESS <u>YAKK 100, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>April 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Butler, Md.</u>			
24. FUNERAL DIRECTOR <u>Isaac Hartenstein, New Freedom</u>				ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04714

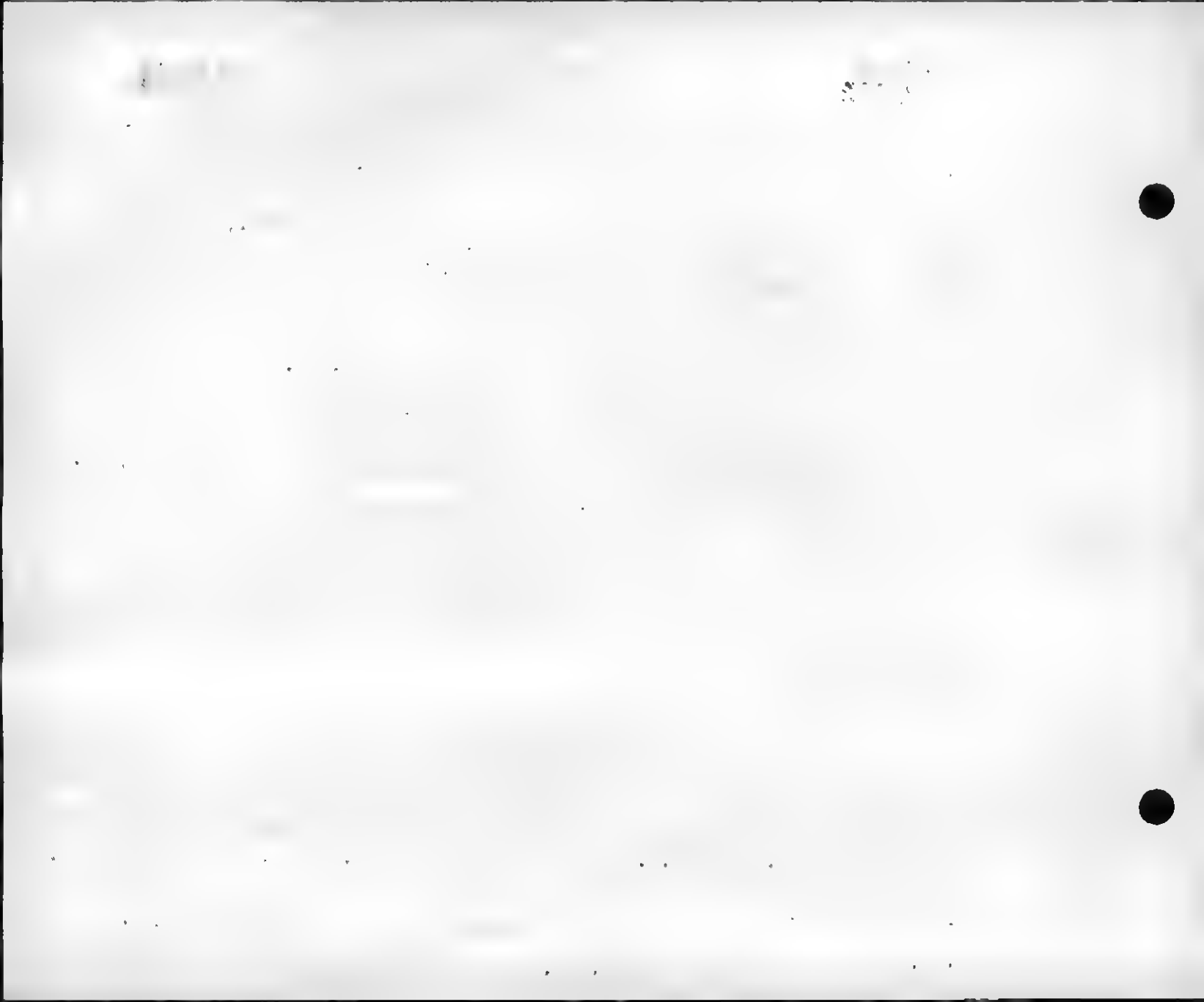
CERTIFICATE OF DEATH

04714

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladenburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>202 McLain Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cheryl</b> Middle <b>Denise</b> Last <b>ETHERIDGE</b>				4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/18/64</b>	
9. AGE (In years last birthday) <b>2</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min		11. BIRTHPLACE (County & State, or foreign country) <b>Bladenburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Bladenburg, Md.</b>	
13. FATHER'S NAME <b>Leroy Ethridge</b>				14. MOTHER'S MAIDEN NAME <b>Hazel Nichols</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT <b>Rosewood Records</b> Address <b>Owings Mills, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO (b) <b>CONGENITAL HYDROCEPHALUS</b> DUE TO (c) <b>LIFE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>Dec. 30, 1964</b> to <b>Apr. 5, 1967</b> , that (H) (we) last saw the deceased alive on <b>April 5, 1967</b> , and that death occurred at <b>9:00 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Joyce M. Boyd</b>				22b. DATE SIGNED <b>4-6-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Joyce M. Boyd, M.D.</b>	
22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 11, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (a) and (b) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



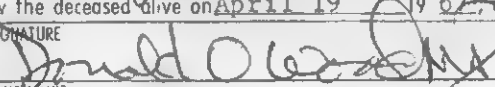
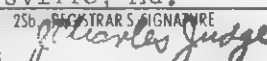
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

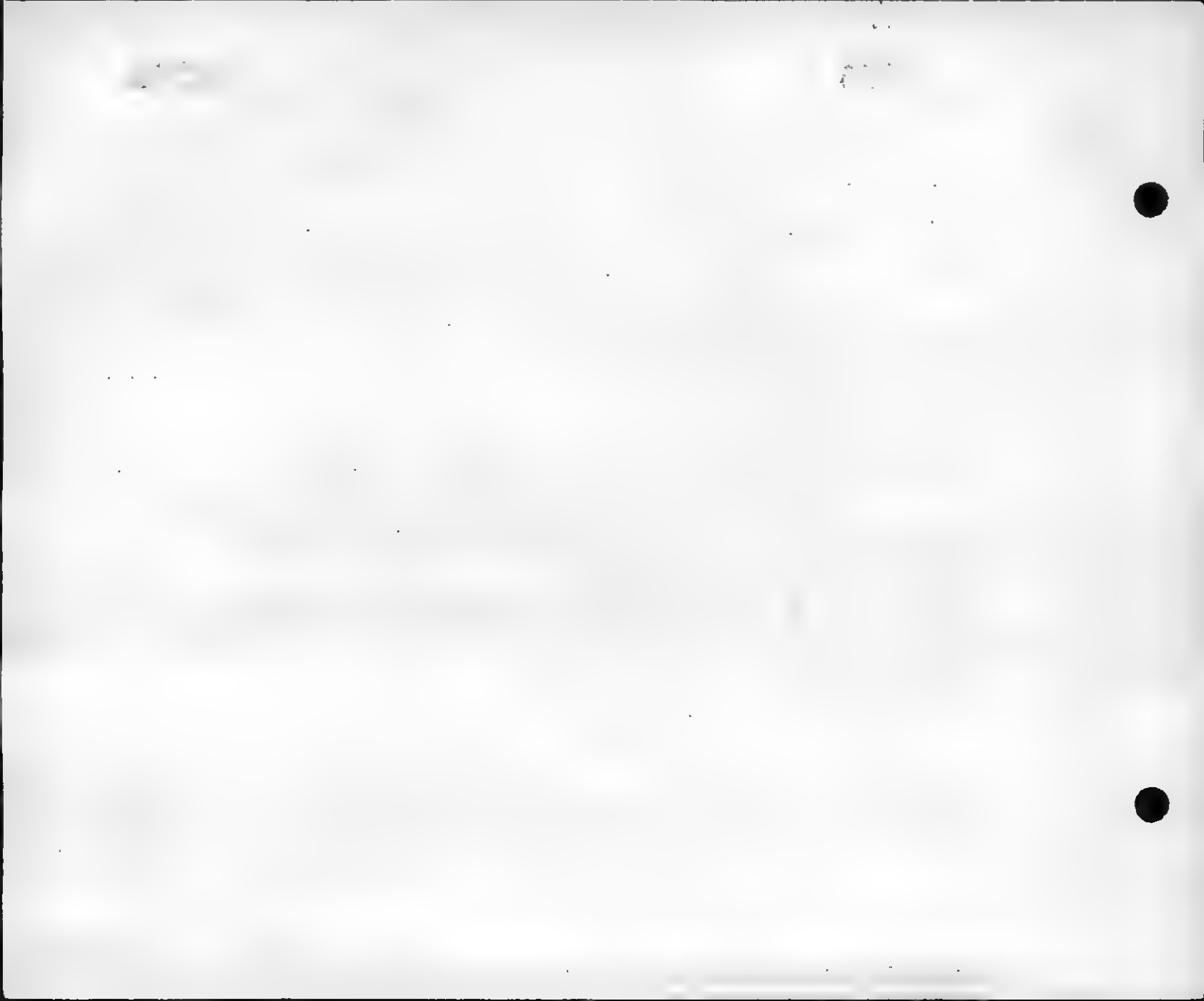
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04715

1 PLACE OF BIRTH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Lutherville</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
3 NAME OF DECEASED (Type or print) <b>David Brinley Evans</b>		4 DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 67</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 2, 1889</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Order Clerk</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Wales</b>
13 FATHER'S NAME <b>Thomas Evans</b>		14 MOTHER'S MAIDEN NAME <b>Anne Daniels</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>213-07-7993</b>	17 INFORMANT <b>Miss Lillian M. Evans 17 Alston Rd. 21093</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest due to myocardial infarction due to arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO <b>2 years</b> DUE TO <b>20 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>20 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (If this hospital) attended the deceased from <b>April</b> , 1965 to <b>April 19</b> , 1967, that (I) (we) saw the deceased alive on <b>April 19</b> , 1967, and that death occurred at <b>8:50 P.M.</b> , from causes and on the date stated above			
22a. SIGNATURE 		22b. DATES SIGNED <b>4-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD O. WOOD, M.D.</b>		22d. ADDRESS <b>York Road and Greenmeadow Dr. Timonium, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	25b. REGISTRAR'S SIGNATURE 





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

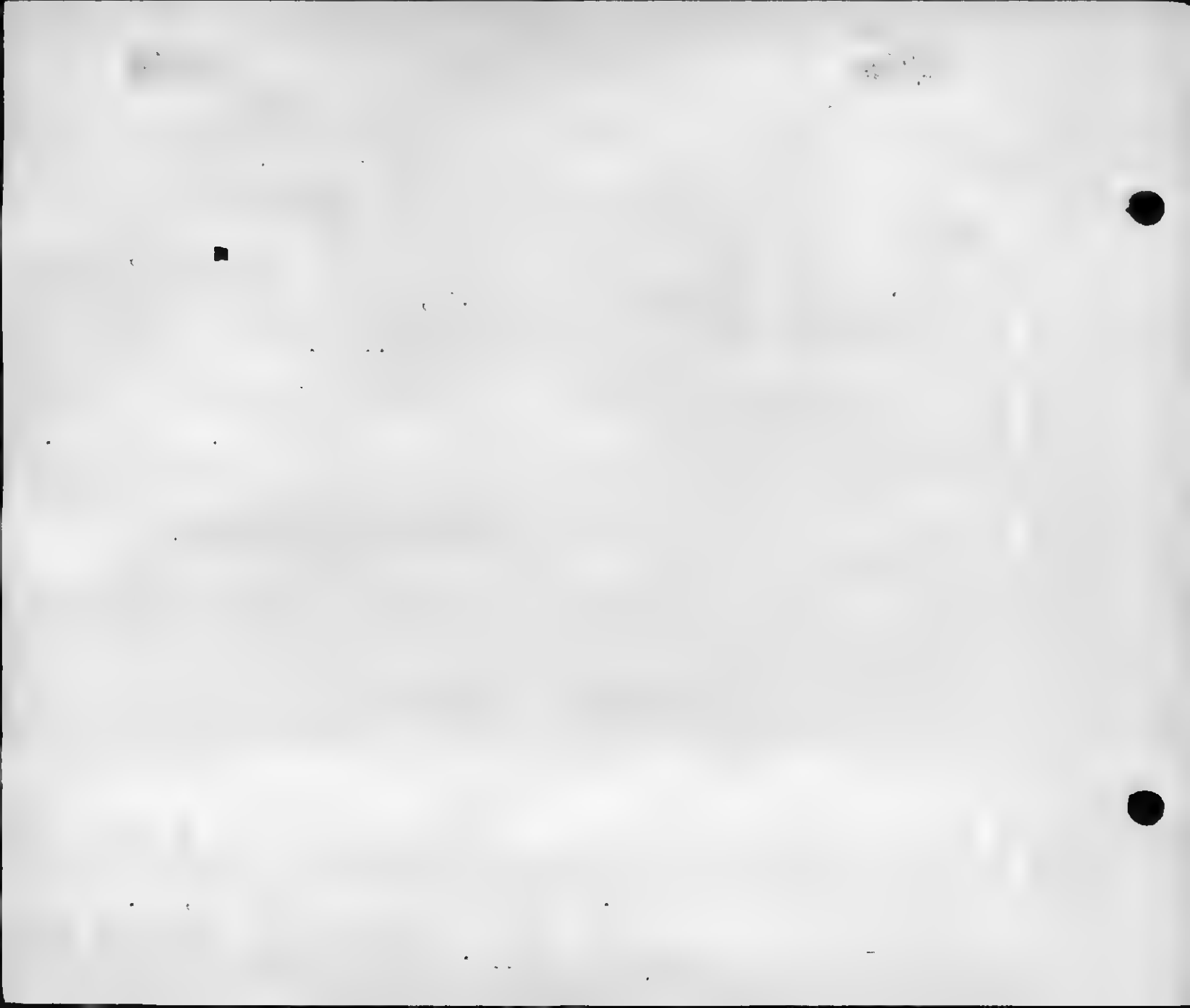
04716

Item #2c & d F. in #3300 7/2/67

CERTIFICATE OF DEATH

04716

1. PLACE OF DEATH = COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson/ Balto.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Presbyterian Home</b>		d. STREET ADDRESS <b>2305 Denmore Ave. Dixie Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>Lena</b> Last <b>FALCON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herman Waydeline</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Glek</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Presbyterian Home of Md. Towson, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 1958 to APRIL 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 26, 1967</b> , and that death occurred at <b>2:32 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>S. J. VENABLE, JR MD</b>		22b. DATE SIGNED <b>MAY 1 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. J. VENABLE, JR MD</b>		22d. ADDRESS <b>7215 YORK RD BALTIMORE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/2/67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mitchell-Wiedefeld Home</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 3 1967</b>	
ADDRESS <b>6500 York Rd. Balto., Md. 21212</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

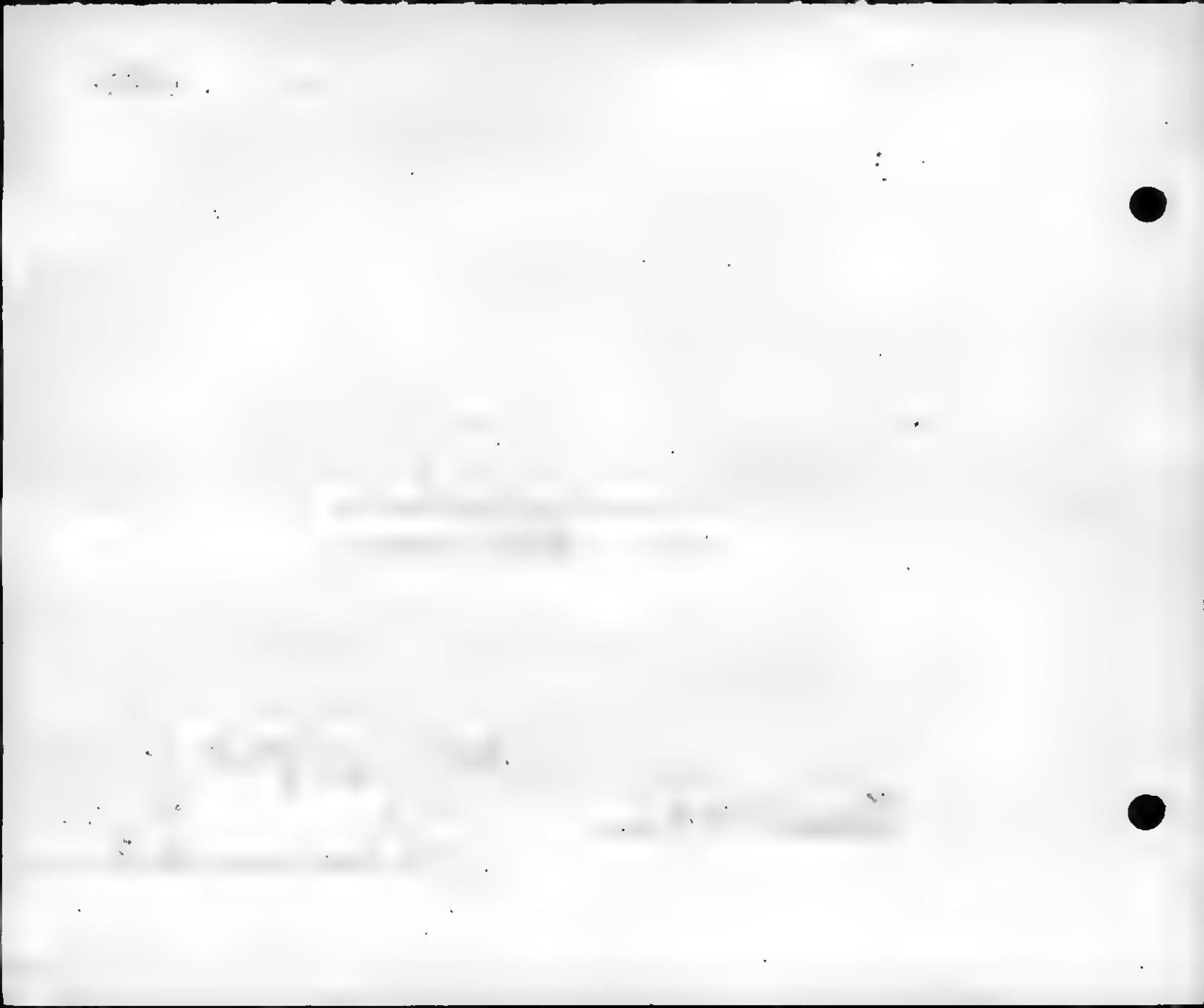
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04717

04717

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box-190 - Dogwood Rd.</b>				d. STREET ADDRESS <b>Box-190 - Dogwood Rd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS DAVID FANTOM</b>				4. DATE OF DEATH Month Day Year <b>APRIL 20 1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 3, 1899</b>	9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR SELF</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>JOHN H.</b>				14. MOTHER'S MAIDEN NAME <b>EMMALINE MCGEE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>217-07-0051</b>		17. INFORMANT Address <b>Mrs. Alice Fantom - Dogwood Rd. #7</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Atherosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>64</b> to <b>April 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 19, 1967</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas Palagias</b>				22b. DATE SIGNED <b>4/21/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Thomas Palagias</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Forley, Coram &amp; Co. Catonsville, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #504711/19/67 ps

04718

CERTIFICATE OF DEATH

04718

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if instnat on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. LENGTH OF STAY IN 1b <b>8 yrs</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				d. STREET ADDRESS <b>2209 Wilker avenue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2209 Wilker avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>DORIS MAY FENWICK</b>				4. DATE OF DEATH <b>April 13 1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 1, 1921</b>	
9. AGE (In years last birthday) <b>45 yrs</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Harry Lewis</b>			
14. MOTHER'S MAIDEN NAME <b>Marie A. Emmart</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO <b>None</b>				17. INFORMANT <b>Family Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cystic glioma</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>10 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>dehydration, Cerebral hematoma</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1958</b> to <b>Apr 1967</b> , that (II) (we) last saw the deceased alive on <b>Apr 1967</b> , and that death occurred at <b>8:00 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Frank J. Kasik</b>				22b. DATE SIGNED <b>4/15/67</b>		22c. PHYSICIAN'S NAME (Type) <b>FRANK J. KASIK JR MD</b>	
22d. ADDRESS <b>9005 Harford road</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, balto. Md.</b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>				25a. REC'D BY REGISTRAR <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

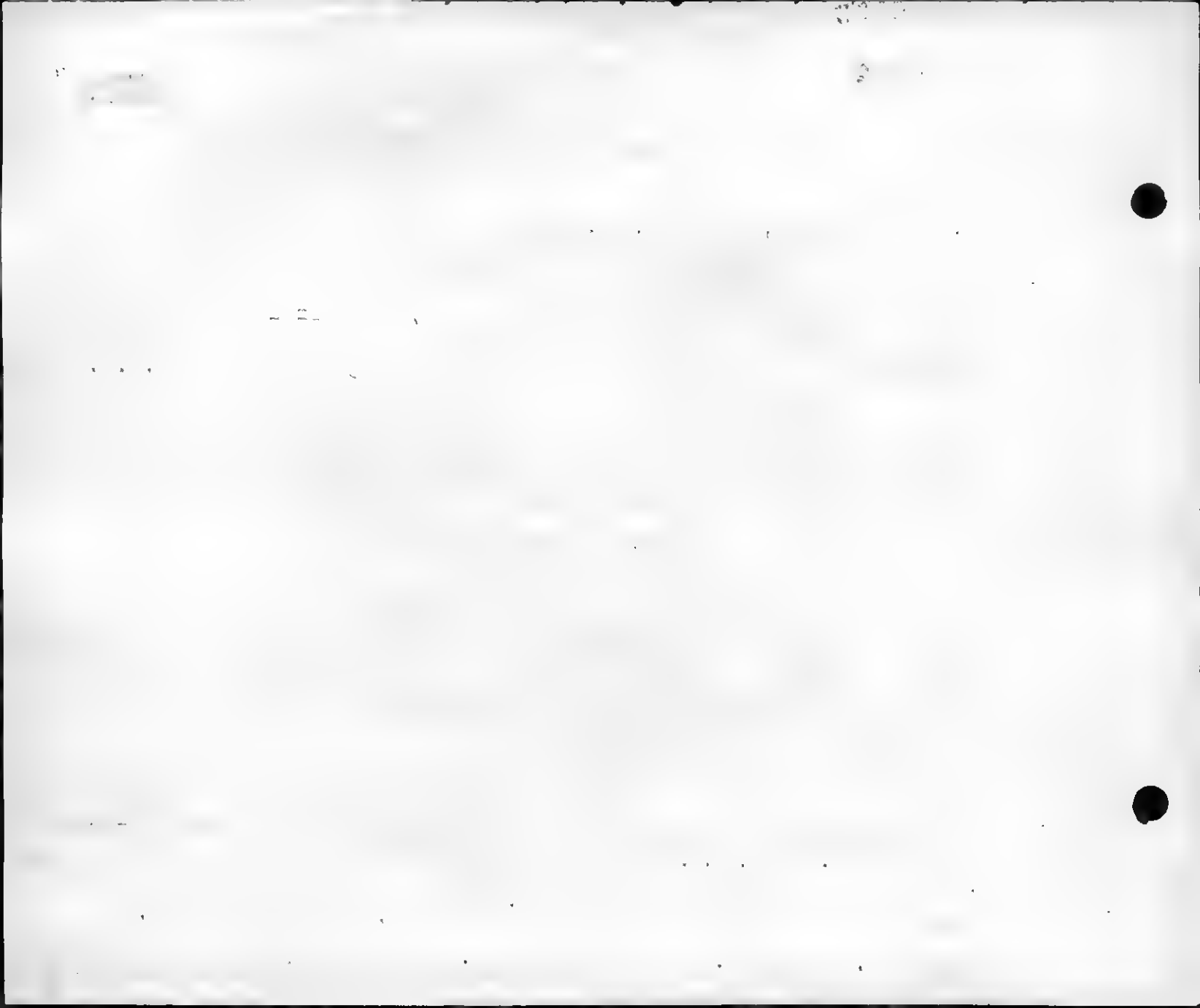
## CERTIFICATE OF DEATH

04719

04719

<b>1 PLACE OF DEATH</b> a COUNTY <b>Baltimore</b> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c LENGTH OF STAY IN 1b  d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, Baltimore, Md. 2204</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution of Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d STREET ADDRESS <b>6116 Sefton Avenue 21214</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <b>AGNES FERRUGGIO</b>		<b>4 DATE OF DEATH</b> Month Day Year <b>April 16 19 67</b>	
<b>5. SEX</b> <b>Female</b>	<b>6 COLOR OR RACE</b> <b>White</b>	<b>7 MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>4-25-04</b>
<b>9 AGE</b> (In years last birthday) <b>63-62</b> yrs <b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10b KIND OF BUSINESS OR INDUSTRY</b>  <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>	<b>12 C.T. ZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13 FATHER'S NAME</b> <b>William McDonough</b>		<b>14 MOTHER'S MAIDEN NAME</b> <b>Nora ?</b>	
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (If yes give war or dates of service) <b>no</b>		<b>16 SOCIAL SECURITY NO.</b>  <b>17 INFORMANT</b> <b>Husband Pietro Ferruggio</b> Address <b>Same as patient</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Diabetic Coma</b> DUE TO (b) <b>Cerebral vascular hemorrhage</b> DUE TO (c)			<b>INTERVAL BETWEEN ONSET AND DEATH</b>  
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Chronic hypertensive heart disease</b>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d INJURY OCCURRED</b> While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>4-3-67</b> , 19 <b>67</b> , to <b>4-16</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>4-16-</b> 19 <b>67</b> , and that death occurred at <b>10:00</b> M, from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>E. Reyes, M.D.</b>		<b>22b. DATE SIGNED</b> <b>4-16-67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>E. Reyes, M.D.</b>		<b>22d. ADDRESS</b> <b>7620 York Road, Baltimore, Maryland 21204</b>	
<b>23a BURIAL, CREMATION, REMOVAL, (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>4/19/67</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cem.</b>	<b>23d LOCATION (City or Town) (County) (State)</b> <b>Baltimore, Md.</b>
<b>24 FUNERAL DIRECTOR</b> <b>Leonard J. Ruck, inc. 5305 Harford Rd.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 17 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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20 M 1/66

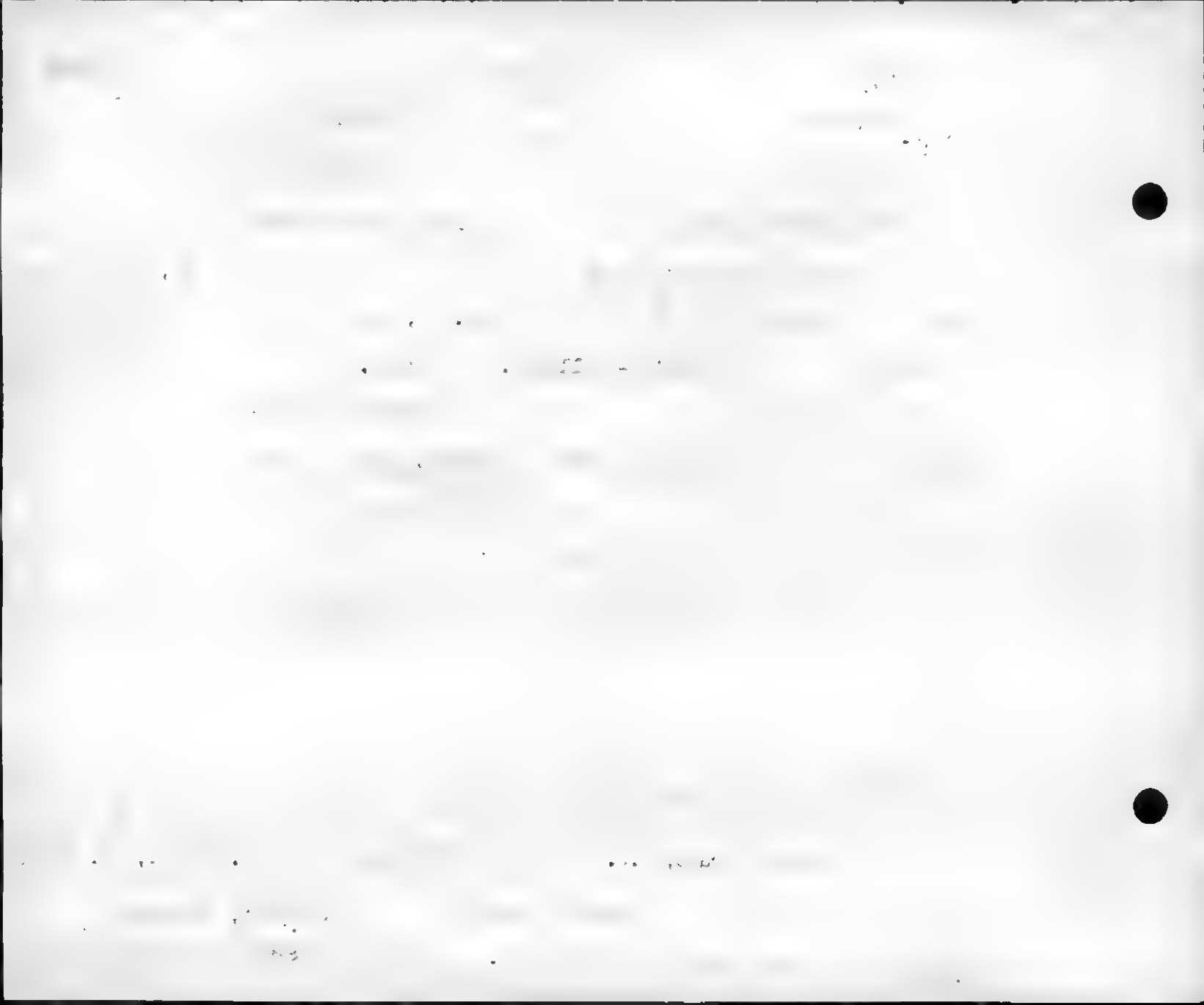
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04720

04720

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1023 Eastern Avenue</b>				d STREET ADDRESS <b>1023 Eastern Avenue</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL LINDERMAN FINCH</b>				4 DATE OF DEATH Month Day Year <b>April 11, 19 67</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1903</b>		9 AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Proctor-Gamble Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Joseph Finch</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Linderman</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16 SOCIAL SECURITY NO <b>218 01 2228</b>		17 INFORMANT <b>Margaret Finch</b> Address <b>Same</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Arteriosclerosis -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Diabetes mellitus -</b>						INTERVAL BETWEEN ONSET AND DEATH <b>None</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-6</b> , 19 <b>66</b> , to <b>4-10</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>4-10</b> , 19 <b>67</b> ; and that death occurred at <b>7:30 P.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Leopoldo Gruss</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leopoldo Gruss, M.D.</b>				22d. ADDRESS <b>405 Stemmers Run Rd. Balto., Md. 21221</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>				25a. REC'D BY REGISTRAR <b>APR 13 1967</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04721

CERTIFICATE OF DEATH

04721

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> <u>6614 Cheewood Road</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c LENGTH OF STAY IN 1b <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Beverlee ANN Finkelstein</u>		4 DATE OF DEATH <u>April 27 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>IV</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-28-23</u>
9. AGE (In years last birthday) <u>43 yrs</u>		10. F UNDER 1 YEAR Months Days Hrs Mns IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State or foreign country) <u>MITCHELL SOUTH DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Itai fetz</u>		14. MOTHER'S MAIDEN NAME <u>Hattie S. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT <u>MR. JONAH B. FINKELSTEIN, 6614 CHEEWOOD RD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>163x</u> DUE TO <u>Terminal Ca of the lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with diffuse metastasis.</u> (c) <u>with diffuse metastasis.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> , 19 <u>67</u> , to <u>4-27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-27</u> , 19 <u>67</u> , and that death occurred at <u>1:50 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Diadema Simon, MD</u>		22b. DATE SIGNED <u>4-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DRADENA SIMON</u>		22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHALOM MEMORIAL PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>ILLINOIS</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

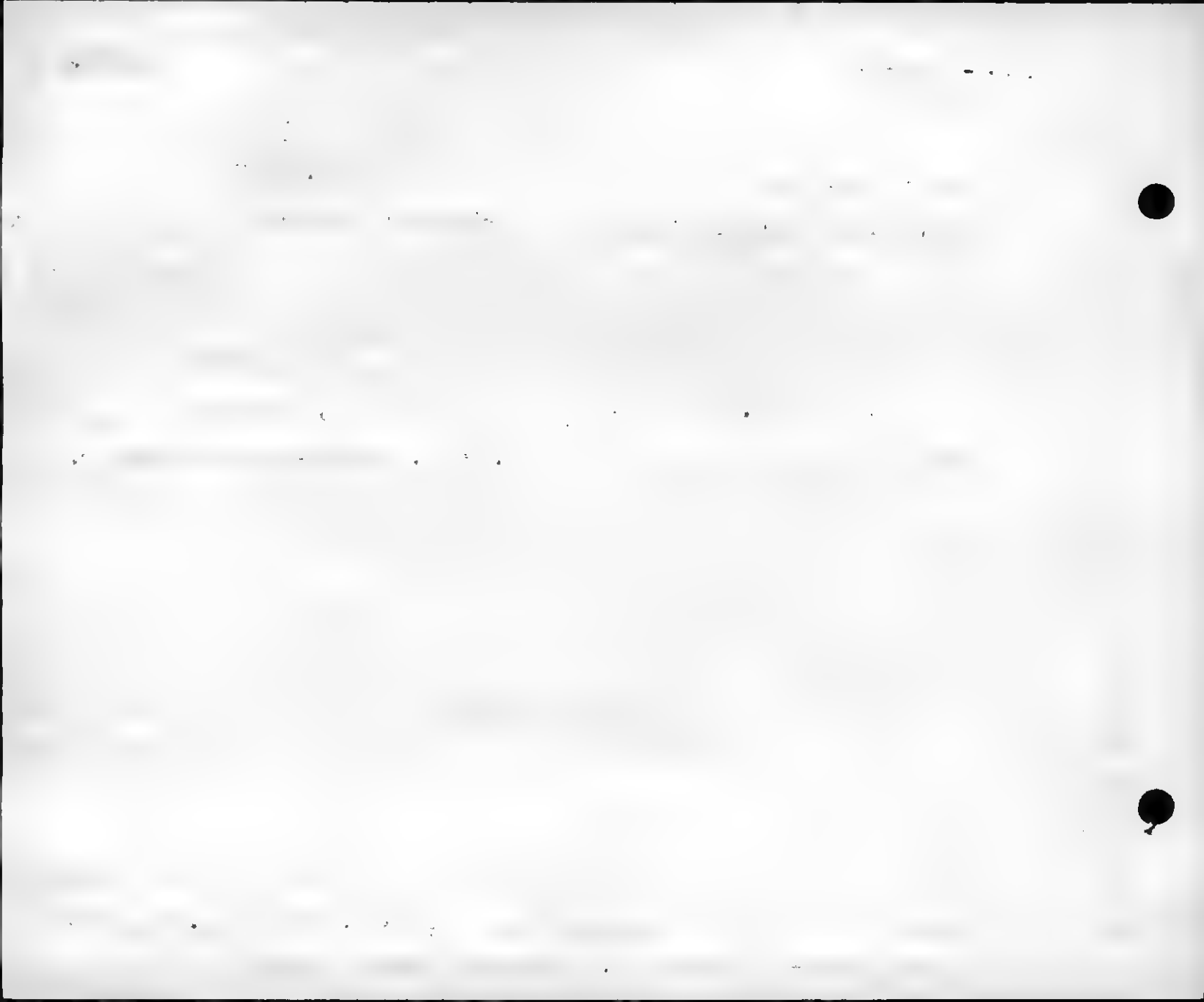


CERTIFICATE OF DEATH

04722

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RJAL and give nearest town) <u>Balt. 21207</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balt. County General Hospital</u>		d. STREET ADDRESS <u>8400 Merrymount Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY L. FINNISEY</u>		4. DATE OF DEATH Month Day Year <u>4 27 1967</u>	
5. SEX <u>M</u>	6. CO. OR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-01</u>
9. AGE (In years last birthday) <u>65</u> yrs		F UNDER 1 YEAR Months Days F UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pa. Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George A. Finnisey</u>		14. MOTHER'S MAIDEN NAME <u>Baker, Catherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>21207</u>	
17. INFORMANT <u>Mr. Lee R. Finnese - 8400 Merrymount Dr.</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-26, 1967</u> to <u>4-27, 1967</u> that (I) (we) last saw the deceased alive on <u>4-27, 1967</u> , and that death occurred at <u>1:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Antonio R. Jara</u> M.D.		22b. DATE SIGNED <u>4-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO R. JARA</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	23d. LOCATION (City or town) (County) (State) <u>6 E. Franklin St. Balt. 21202</u>
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown</u>		25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

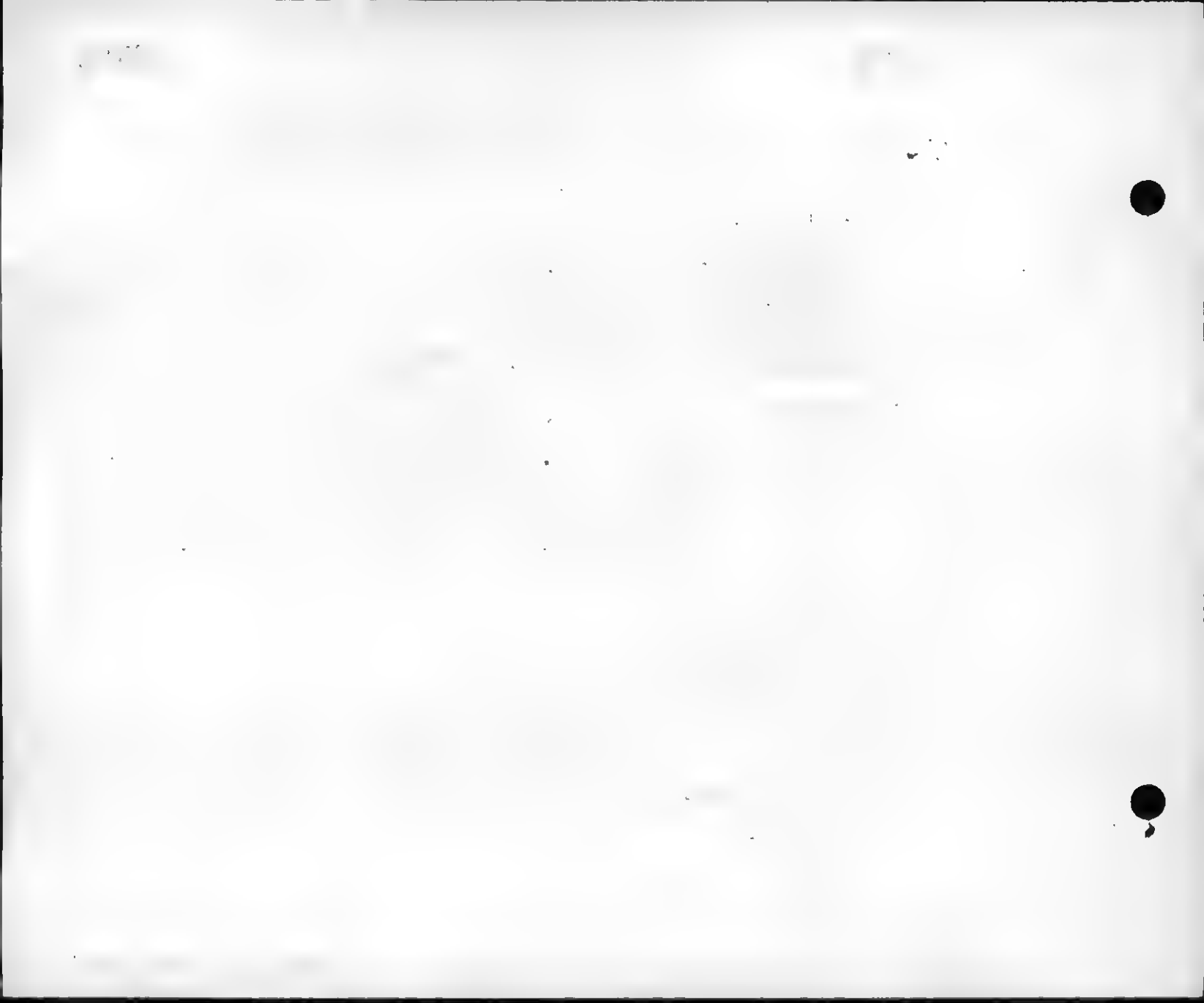
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04723

04723

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BALTIMORE</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c LENGTH OF STAY N 1b <u>1 DAY</u>		d STREET ADDRESS <u>1508 COVINGTON ST.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>STELLA MARIS HOSPICE</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWARD FISCHER</u>		4 DATE OF DEATH Month Day Year <u>APR. 10, 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 20, 1912</u>
9 AGE (In years last birthday) <u>54</u> yrs		10 UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer Boilers Institution</u>		11 BIRTHPLACE (State or foreign country) <u>ELKTON, MD, Co, Md</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>JOHN FREDERICK FISCHER</u>	
14 MOTHER'S MAIDEN NAME <u>EDITH ESTELLE WOOTEN</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16 SOCIAL SECURITY NO. <u>218-97-7075</u>		17 INFORMANT <u>HENRY J. FISCHER (DPO) - Same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Disease</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 + yrs</u> <u>5 + yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS A TOLPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22 ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>		23 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24 EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		25 ADDRESS (Street, city, town or county) <u>BALTO, MD</u>	
26 BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		27 DATE THEREOF <u>APR 13 1967</u>	
28 NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		29 LOCATION (City or town) (County) (State) <u>BALTIMORE, MD</u>	
30 FUNERAL DIRECTOR <u>CURTIS E. EVANS</u>		31 ADDRESS <u>1400S. CHARLES ST BALTO, MD</u>	
32 REC'D BY REGISTRAR <u>APR 11 1967</u>		33 REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #G187 371 731 pc

04724

CERTIFICATE OF DEATH

04724

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3207 E. Joppa road</b>				d. STREET ADDRESS <b>3207 E. Joppa road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>REID S. FISHPAW</b>				4. DATE OF DEATH Month Day Year <b>April 11 19 67</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7 1913</b>	9. AGE (In years last birthday) <b>53 5/4 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO CO WATER</b>		11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>GUR R. FISHPAW</b>				14. MOTHER'S MAIDEN NAME <b>HILDA TRACEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW 2</b>			16. SOCIAL SECURITY NO <b>218-09-2241</b>		17. INFORMANT <b>FAMILY RECORDS</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial degeneration Stokes Adams</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease 1-24</b> DUE TO <b>with Coronary artery Disease</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A TAPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> , to <b>April 1967</b> , that (II) (we) last saw the deceased alive on <b>April 4 1967</b> , and that death occurred at <b>11 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Frank Kasik</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/12/67</b>
22c. PHYSICIAN'S NAME (Type) <b>FRANK KASIK M.D.</b>			22d. ADDRESS <b>9005 Harford road</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO NAT CEM</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>				25a. REC'D BY REGISTRAR <b>APR 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

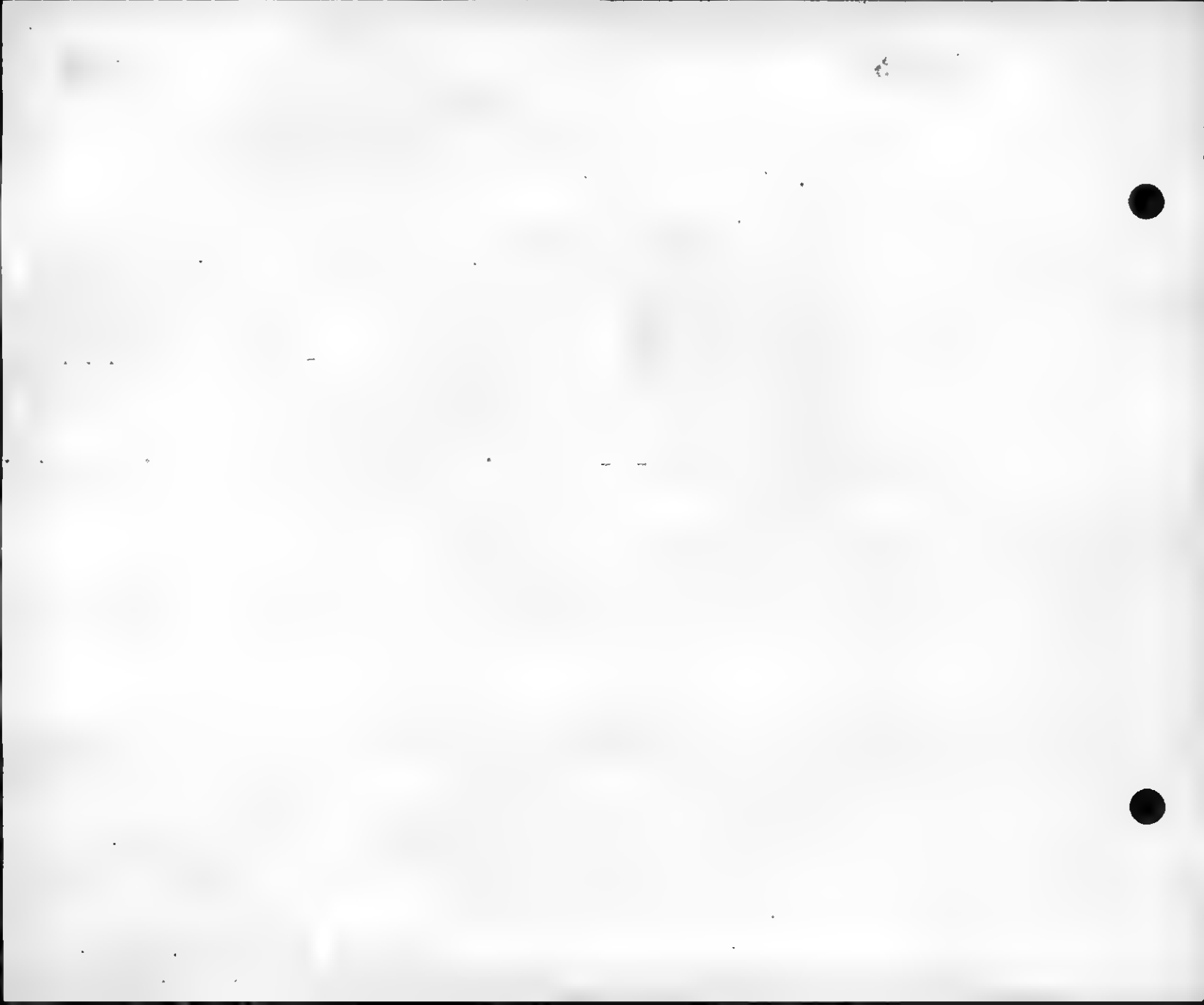
04725

## CERTIFICATE OF DEATH

04725

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Rhode Island</b> b. COUNTY <b></b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Balto. City</b>			c. LENGTH OF STAY IN 1b <b>1 da</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chepachet</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3626 Sylvan Drive Balto 7, Md</b>				d. STREET ADDRESS <b>Oil Mill Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Gladys</b> Last <b>Flynn</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1900</b>	9. AGE (In years last birthday) yrs. <b>66</b>	10. IF UNDER 1 YEAR Months <b></b> Days <b></b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State or foreign country) <b>Blackstone, Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Chapman</b>				14. MOTHER'S MAIDEN NAME <b>Mary Tierney Daniels</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>038-16-0445</b>		17. INFORMANT Address <b>Mr. John Torpey 3626 Sylvan Dr. Balto 7, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ASHD</b> DUE TO (c) <b>diabetes, mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/8/67</b> , 19 <b>67</b> , to <b>4/8/67</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>4/8</b> , 19 <b>67</b> , and that death occurred at <b>4:00</b> M. from causes and on the date stated above.							
22a. SIGNATURE <b>Milton Schlenker</b>				22b. DATE SIGNED <b>4/8/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Milton Schlenker</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Patrick</b>		23d. LOCATION (City or Town) (County) (State) <b>Pascoag Rhode Isl.</b>	
24. FUNERAL DIRECTOR <b>Spring Myers 8728 Liberty Rd</b>				25a. REC'D BY REGISTRAR <b>APR 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04726

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Texas</b>			c. LENGTH OF STAY in years <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Texas</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9932 Ellengowan Road</b>				d. STREET ADDRESS <b>9932 Ellengowan Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>MAY</b> Last <b>FORD</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1918</b>		9. AGE (In years last birthday) <b>48</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Assem</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Homer Gover</b>				14. MOTHER'S MAIDEN NAME <b>Nellie May Free</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>???</b>		17. INFORMANT <b>Mr. James E. Ford, Sr., Same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>April 14, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>				25a. REC'D BY REGISTRAR <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

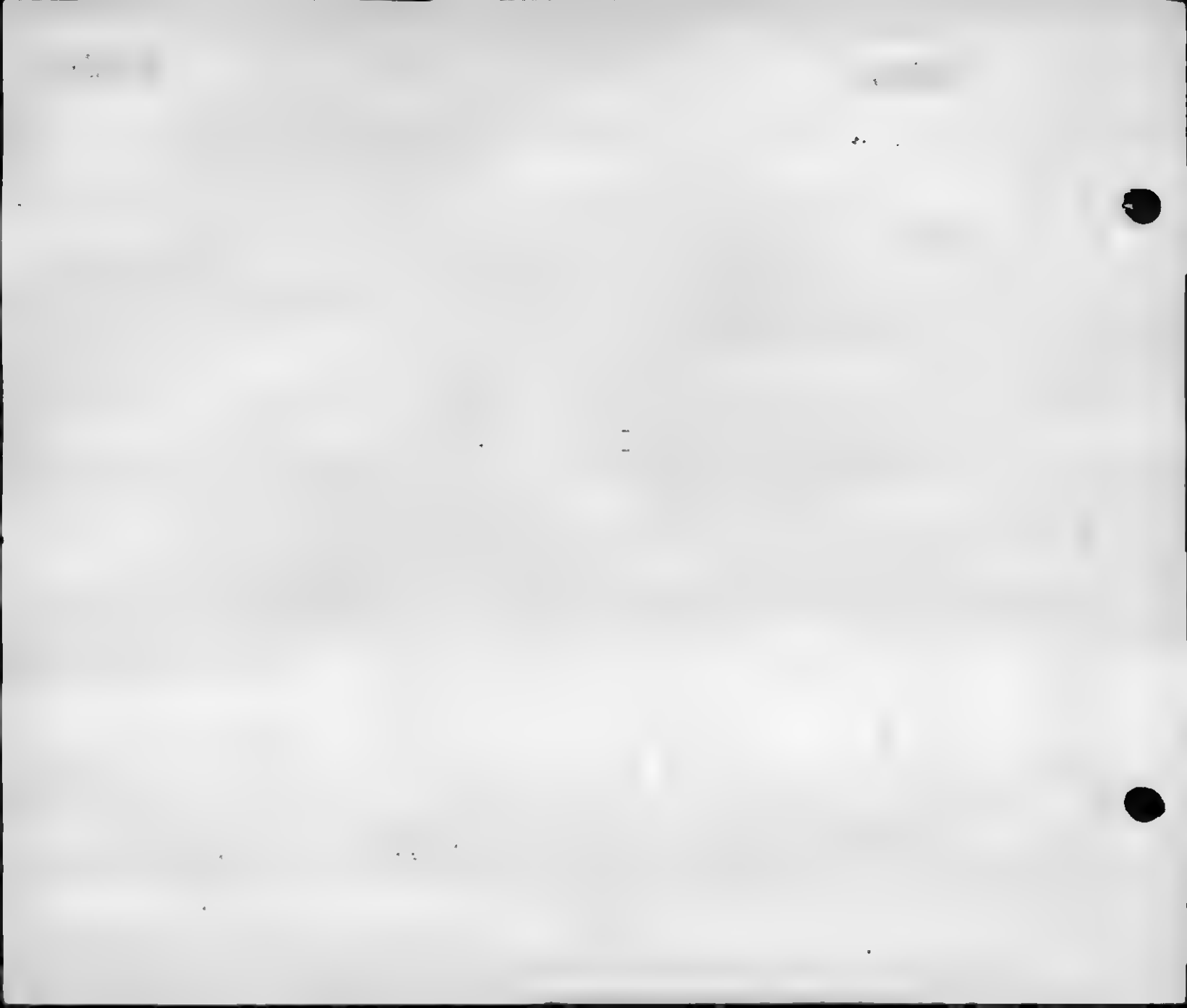
04727

04727

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		d. STREET ADDRESS <u>4 Wengate Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4 Wengate Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mamie Elizabeth Fortmiller</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 24, 1892</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gustav Musch</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Moser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-4996D</u> <u>213-34-0552</u>		17. INFORMANT Address <u>Mrs. Doris Dixon, 4 Wengate Rd, Owings Mills</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - breast</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Metastasis to liver</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH: <u>1 year</u> <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 1966</u> to <u>April 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 8, 1967</u> , and that death occurred at <u>2:00</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Clarence E. McWilliams</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Clarence E. McWilliams</u>				22d. ADDRESS <u>11904 Rustentown Rd, Rustentown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>April 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. - Baltimore, Md. -- 14</u>				25a. REC'D BY REGISTRAR DATE <u>4-10-1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>William J. Ruck</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (a) and (b) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

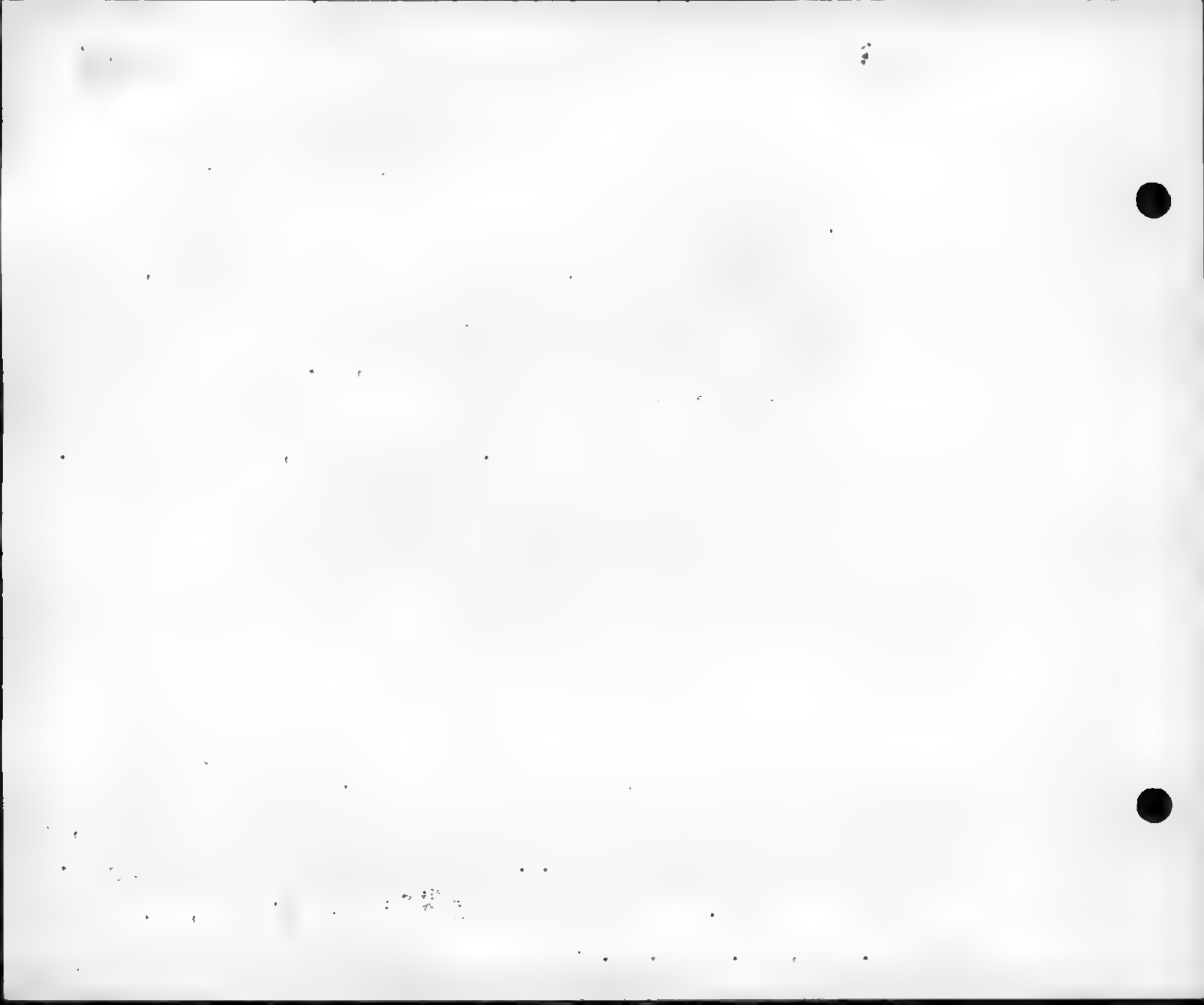
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04728

04728

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>3016 Northern Parkway</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret A. Fox</b>		4. DATE OF DEATH Month Day Year <b>April 23, 19 67</b>	
5. SEX <b>Female</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-17-91</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sebastian Miller</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ferncase</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Robert Deppisch</b>		Address <b>3024 Fleetwood Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of right breast with widespread metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 16, 1967</b> to <b>April 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 23, 19 67</b> and that death occurred at <b>11:50 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>J. Ambrad</i> M.D.		22b. DATE SIGNED <b>April 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jaime Ambrad M.D.</b>		22d. ADDRESS <b>7620 York Road -Towson 21204, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/27/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>APR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <i>J. Ambrad</i>



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

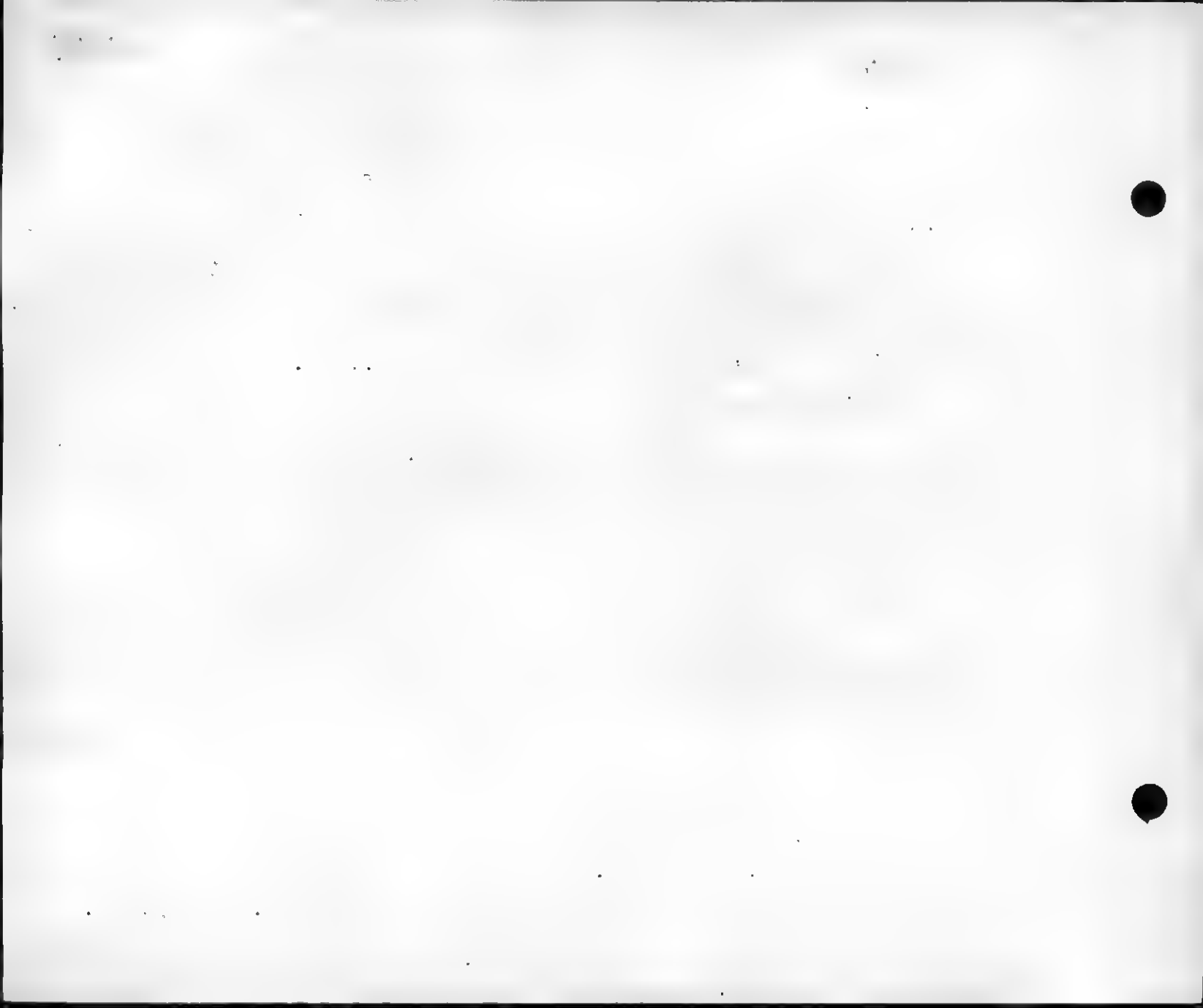
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04723

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04729

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d. STREET ADDRESS <b>2110 Triandos Drive</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>EVA Ness FRANTZ</b>		4 DATE OF DEATH Month Day Year <b>4 18 19 67</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/10/1901</b>
9 AGE (In years last birthday) <b>65</b> yrs		10 UNDER 1 YEAR Months Days 11 UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Organist - Episcopal Church</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>William Ness</b>		14 MOTHER'S MAIDEN NAME <b>Claudia Vaughn</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Luther M. Frantz</b>		Address <b>2110 Triandos Drive</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> or hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>4-19-67</b>			
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF <b>4/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	23d. LOCATION (City or town) (County) (State) <b>Balto. County, Md.</b>
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld</b>		ADDRESS <b>Home 6500 York Rd. Balto., Md. 21212</b>	
25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

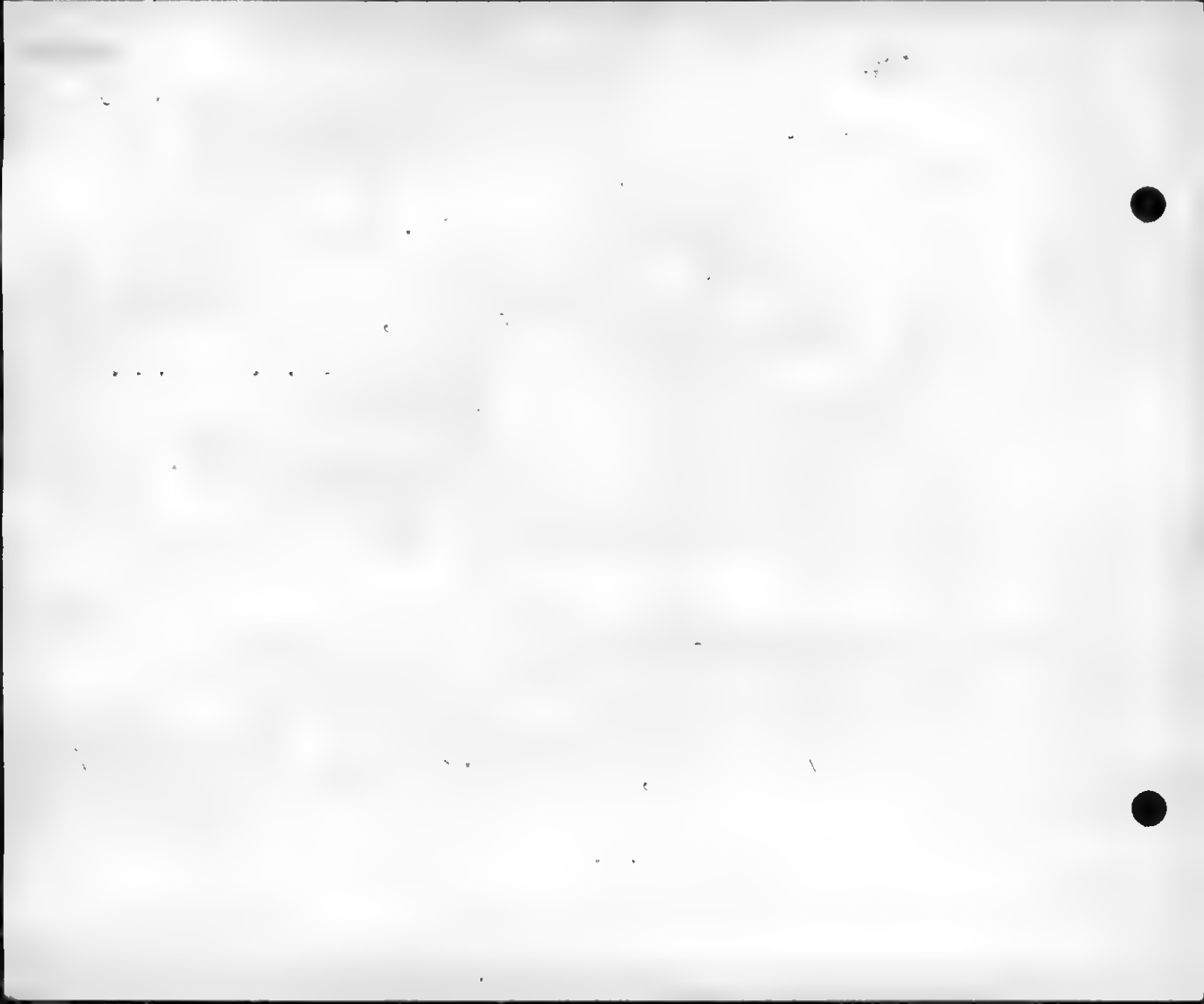
**04730**

**CERTIFICATE OF DEATH**

**04730**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>67 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>231 N. GILMORE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPHUS</b> Middle <b>DAMEL</b> Last <b>FRYAR</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 13, 1916</b>		9. AGE (In years last birthday) <b>51</b> yrs.	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MC LEANSVILLE, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JULIUS FRYAR</b>				14. MOTHER'S MAIDEN NAME <b>SARAH MATTER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>217 18 17 84</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY INFARCTION, RIGHT UPPER LOBE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>PNEUMONIA, UNDETERMINED ORGANISM, RIGHT UPPER LOBE</b> DUE TO (c) <b>DIABETES MELLITUS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
						YEARS	
						19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 24</b> , 1967, to <b>APRIL 1</b> , 1967, that (I) (we) last saw the deceased alive on <b>APRIL 1</b> , 1967, and that death occurred at <b>250AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Neilon Neilson</i> MD				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-5-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE <b>APR 5, 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
Morten & Dyett Funeral Home 1701 Laurens St. Baltimore, Md.							



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04731

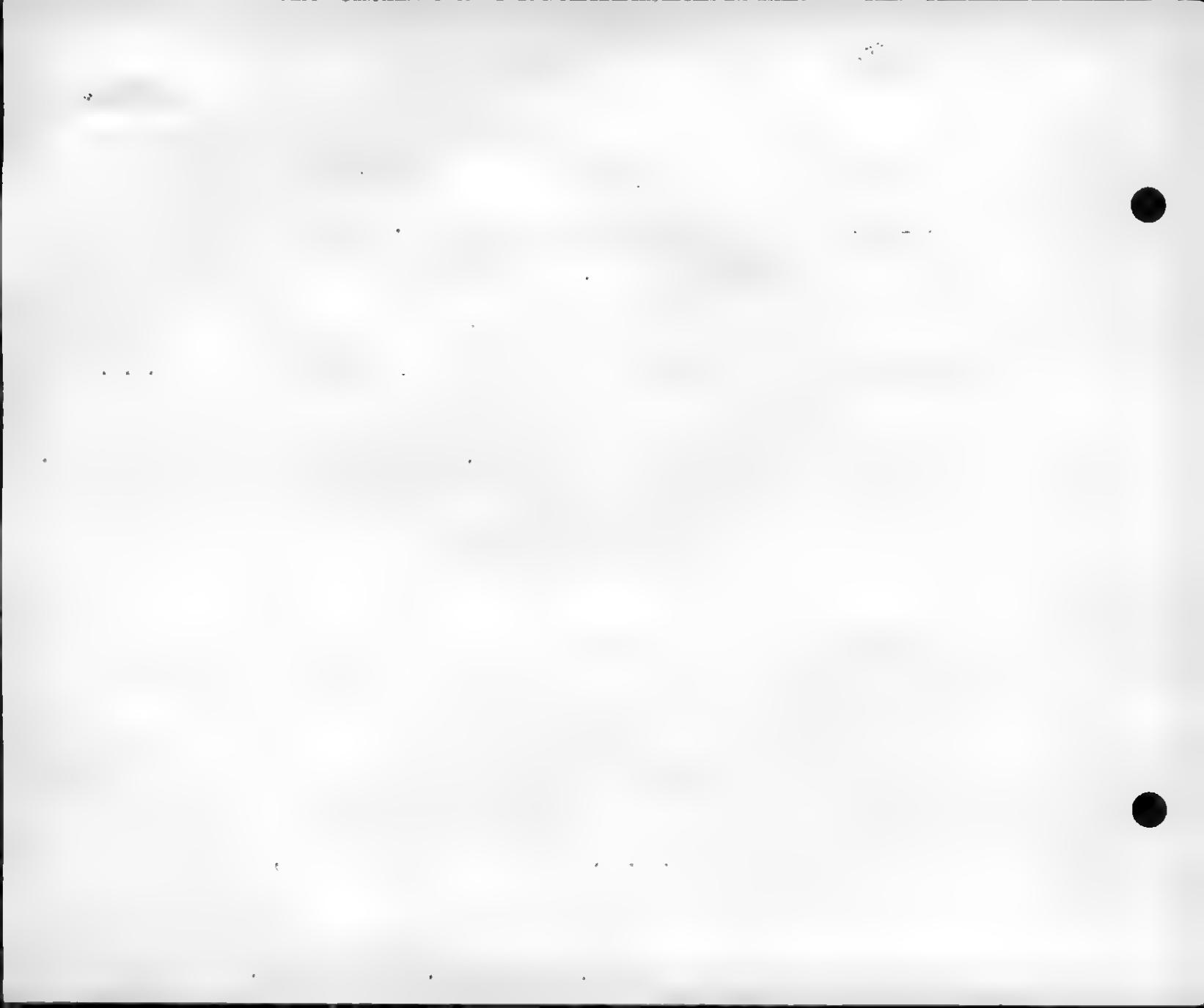
CERTIFICATE OF DEATH

04731

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Res. or admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN It <b>9 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>3102 E. LOMBARD STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>GRIER</b> Middle <b>G.</b> Last <b>FULLERTON</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/01</b>
9 AGE (in years last birthday) <b>66</b>		10. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unk.</b>		14. MOTHER'S MAIDEN NAME <b>unk.</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>209 03 74 38</b>	
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>351X</b> DUE TO Contributans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SUB DURAL HEMORRHAGE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>4/7/67</b> , 19__, to <b>4/16/67</b> , 19__, that (b) we last saw the deceased alive on <b>4/16/67</b> , 19__, and that death occurred at <b>3:25AM</b> , from causes and on the date stated above			
22a SIGNATURE <i>Raul de Castro</i>		22b DATE SIGNED <b>4/17/67</b>	
22c PHYSICIAN'S NAME (Type) <b>RAUL DE CASTRO, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4/19/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a REC'D BY REGISTRAR <b>APR 18 1967</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c REGISTRAR'S NAME <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04732

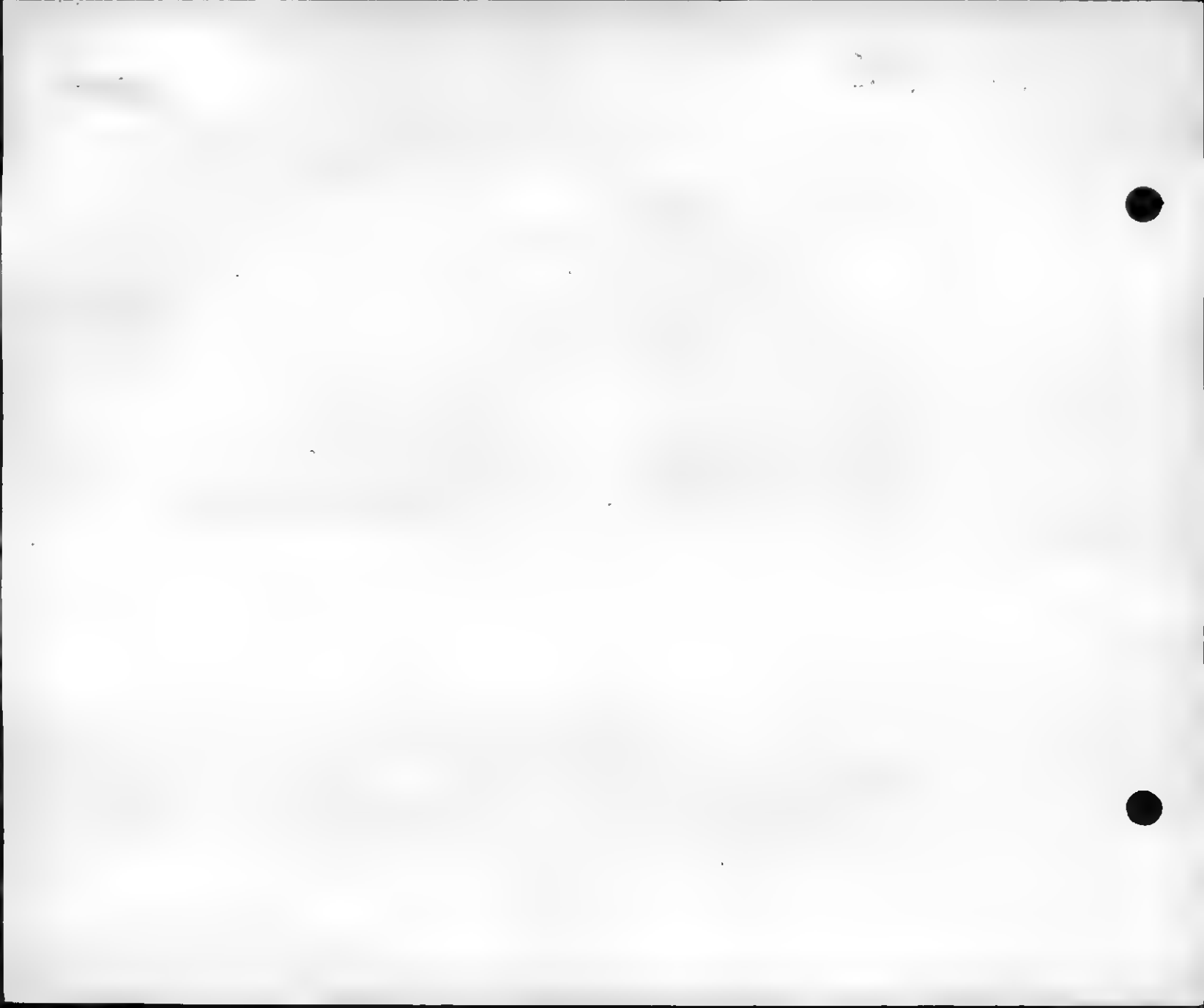
CERTIFICATE OF DEATH

04732

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1604 Claridge Ave. 21227</b>		d STREET ADDRESS <b>1604 Claridge Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>William J. Gallagher</b>		4 DATE OF DEATH <b>April 24 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4/13/95</b>
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b KIND OF BUSINESS OR INDUSTRY <b>B C H D</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>William Gallagher</b>	
14 MOTHER'S MAIDEN NAME <b>Mame MacNinny</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO. <b>220-18-9934</b>		17 INFORMANT Address <b>Mrs. Loretta M. Gallagher 1604 Claridge Ave</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gastro-Intestinal Hemorrhage</b> <b>150X</b> DUE TO (b) <b>Carcinoma of the Esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1965</b> to <b>4/24 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 1966</b> , and that death occurred at <b>2:30 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>James J. Nolan</b> M.D.		22b. DATE SIGNED <b>4/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James J. Nolan</b>		22d. ADDRESS <b>416 Kensington Ave.</b>	
23a BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	23b DATE THEREOF <b>4/27/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a REC'D BY REGISTRAR <b>4107 Wilkens Ave.</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>APR 26 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and return them to the funeral director. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

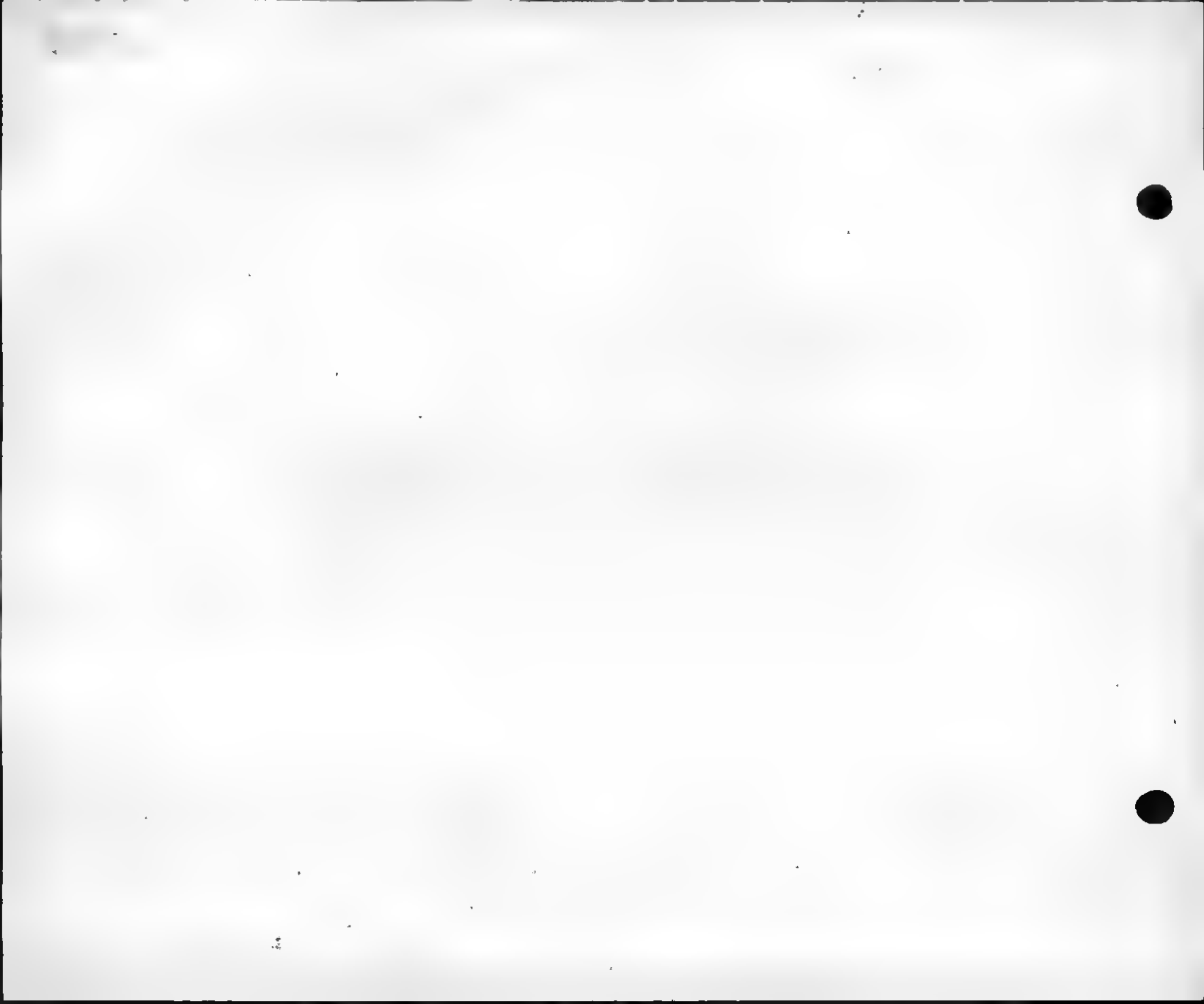
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04733

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		<b>Lutherville 21093</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>34 E. Seminary Avenue</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Susie Gambrill</b>		4 DATE OF DEATH Month Day Year <b>April 8, 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-75</b>
9 AGE (n years last birthday) <b>92</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Md.</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>William Ross Allen</b>		14 MOTHER'S MAIDEN NAME <b>Elinabeth Hoffman</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>Family Records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary thrombo embolism.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <b>Dr. (this hospital)</b> attended the deceased from <b>March 26, 1967</b> to <b>April 8, 1967</b> , that <b>Dr. (we)</b> last saw the deceased alive on <b>April 8, 1967</b> , and that death occurred at <b>12:40 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>April 8, 1967</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>6720 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Apr. 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gunpowder Baptist Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Elko, Balto. Co., Md.</b>
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 12 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

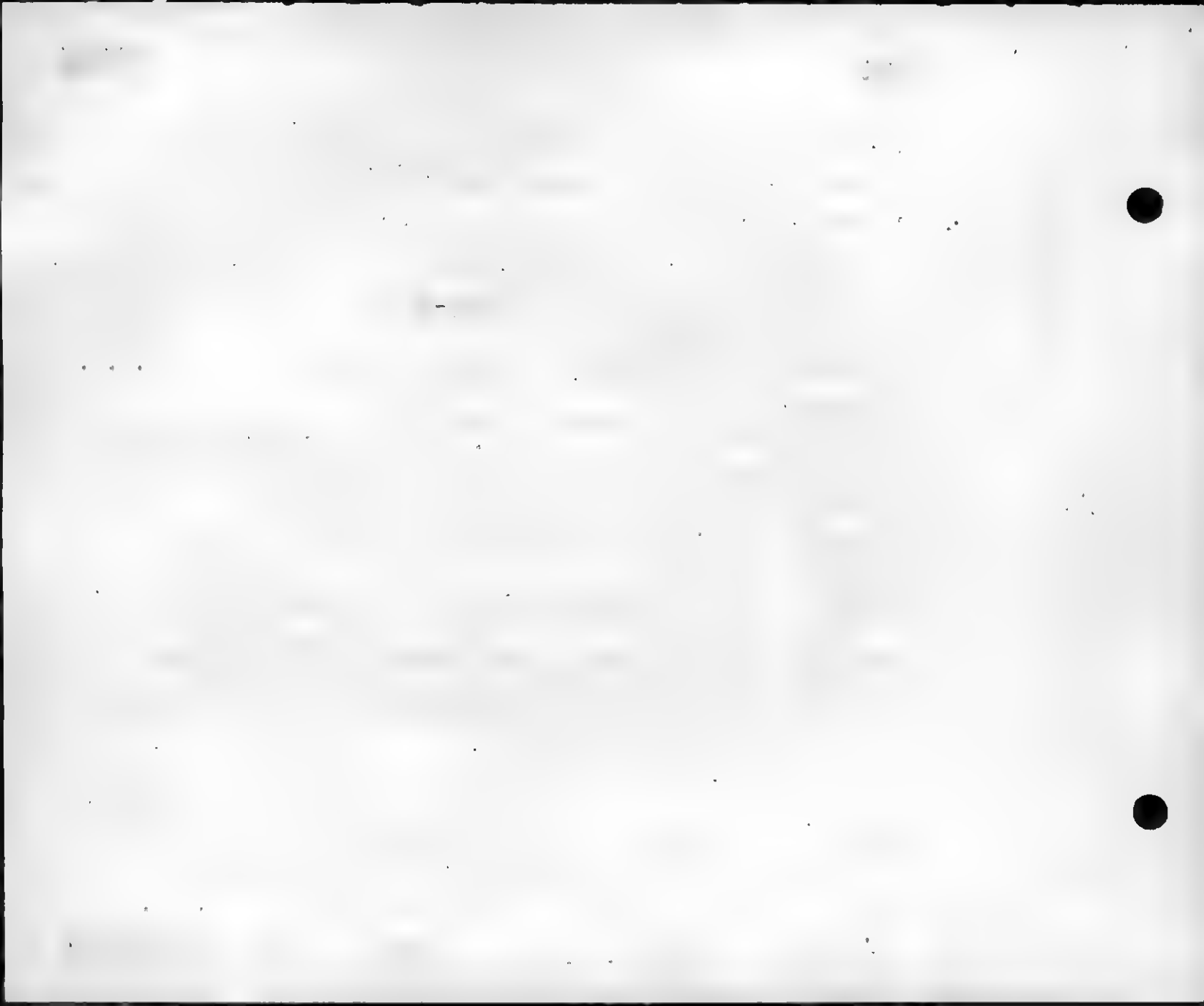


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>04734</b> 1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Armacost Nursing Home</b>						<b>04734</b> 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> d. STREET ADDRESS <b>1410 Kingsway Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Catherine Virginia Gannon</b>			4. DATE OF DEATH <b>April 27 1967</b>			5. SEX <b>F</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>9/16-1876</b>			9. AGE (in years last birthday) <b>90 yrs.</b>			10. IF FUNOER 1 YEAR IF FUNOER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Harris</b>						14. MOTHER'S MAIDEN NAME <b>Sarah</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>_____</b>			17. INFORMANT <b>Mrs. Laurence Sullivan</b>			Address <b>1410 Kingsway Rd</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> DUE TO (b) <b>CHRONIC BRAIN SYNDROME.</b> DUE TO (c) <b>ARTERIOSCLEROSIS GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>5 YEARS+</b> <b>10 YEARS+</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 1951</b> to <b>APRIL 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 27 1967</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Arthur Karfgin</b>						22b. DATE SIGNED <b>4/28/67</b>			22c. PHYSICIAN'S NAME (Type) <b>Arthur Karfgin</b>		
22d. ADDRESS <b>1532 Havenwood Road</b>											
23a. BURIAL, CREMAT., OR REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<b>Entombment</b>			<b>4/29/67</b>			<b>Greenmount Mausoleum</b>			<b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co</b>						25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
4905 York Road, Baltimore, Md. 21212											



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04735

## CERTIFICATE OF DEATH

04735

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chapel Hill Nursing - Randallstown Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21207 Maryland</u> d. STREET ADDRESS <u>8409 Meacham Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Emil</u> First <u>J (GRWEL)</u> Middle <u>Lavel</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1967</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/11/1877</u>		9. AGE (In years last birthday) <u>89</u> yrs. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KING OF BUSINESS OR INDUSTRY <u>Machinist</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matias Lavel</u>				14. MOTHER'S MAIDEN NAME <u>Herminia</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212 10 9283</u>				17. INFORMANT <u>MRS MARY BRANFORD</u> Address <u>8409 Meacham Road Baltimore, Md 21207 M.N.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> 4:01 DUE TO (b) <u>Myocardial C. V. Disease</u> DUE TO (c) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>13 hours</u> <u>5 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12, 1952</u> to <u>April 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1967</u> , and that death occurred at <u>4:05</u> M, from the causes and on the date stated above.																					
22a. SIGNATURE <u>Edwin L. Pierpont</u>												22b. DATE SIGNED <u>4/12/67</u>		22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD - Balt, 21207 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/5/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>				23d. LOCATION (City, town or county) (State) <u>Woodlawn Md.</u>									
24. FUNERAL DIRECTOR <u>J.T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>												25a. REC'D BY REGISTRAR <u>APR 6 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04736

CERTIFICATE OF DEATH

04736

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN TB <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>4213 W. Rogers Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>NMN</u> Last <u>Gershberg</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-25-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years last birthday) <u>72</u> yrs.
11. BIRTHPLACE (County & State or foreign country) <u>MASSACHUSETTS LITH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JONAS GRAZUTIS</u>		14. MOTHER'S MAIDEN NAME <u>ETHEL ELLISON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-3480</u>	
17. INFORMANT <u>Patient's Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>a) BRONCHO PNEUMONIA</u> <u>b) HERNIA WITH HEMORRHAGE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-18-</u> 19 <u>67</u> , to <u>4-28-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-28-</u> 19 <u>67</u> , and that death occurred at <u>10:25AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>E. K. S. Narayanan</u> M.D.		22b. DATE SIGNED <u>4-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. K. S. NARAYANAN, M.D.</u>		22d. ADDRESS <u>GREATER BALTO. MED. CENTER, M.D. 21206</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANSHE EMUNAH-AITZ CHAIN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

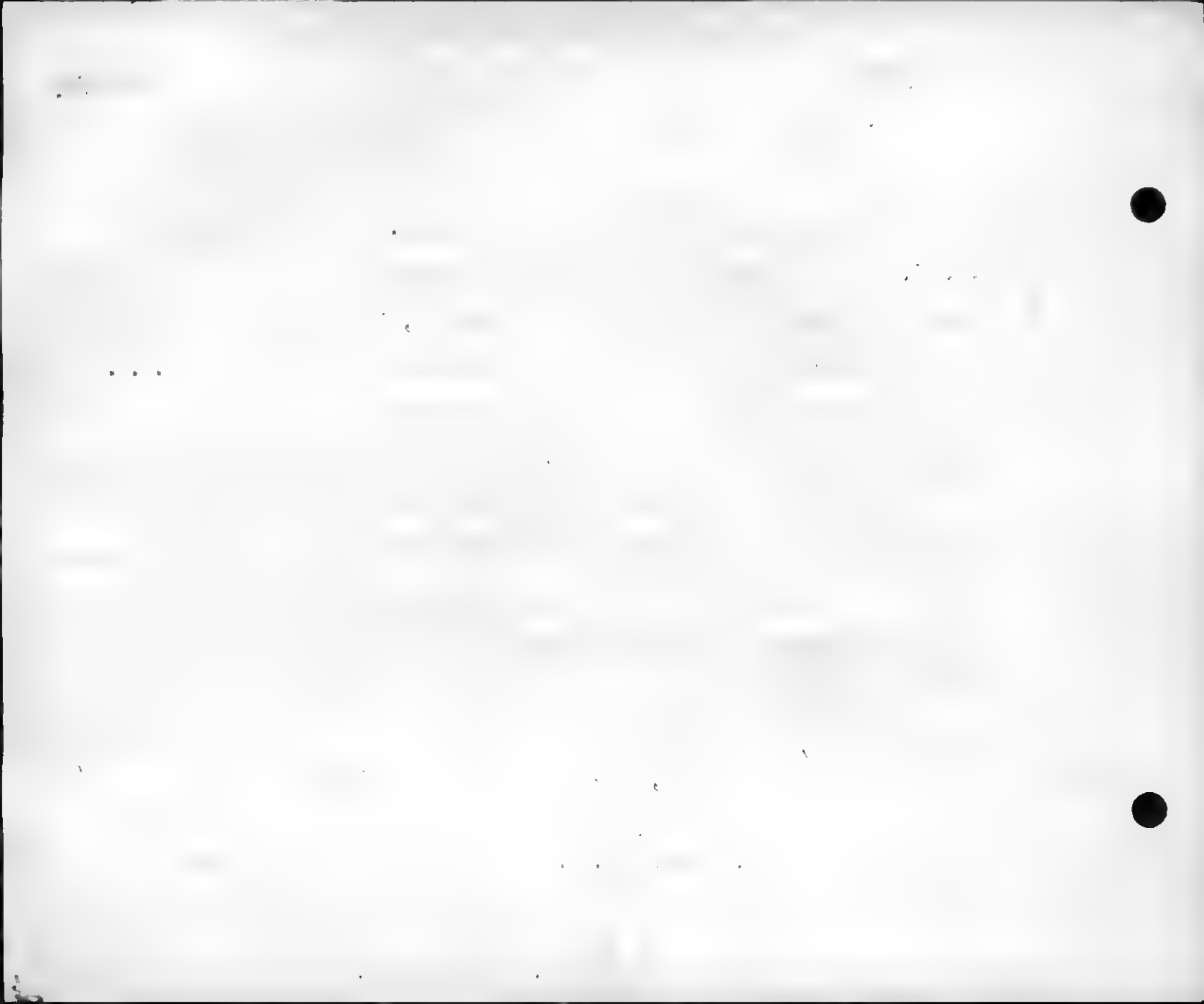
04737

04737

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY in 1b <b>5 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>2050 E. FAYETTE STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HENRY GITTINGS</b>				4. DATE OF DEATH Month Day Year <b>APRIL 4 1967</b>			
5. SEX <b>MALE</b>	6. CO. OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 28, 1916</b>		9. AGE (In years last birthday) <b>50</b> yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE REPAIRMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN FREDERICK GITTINGS</b>				14. MOTHER'S MAIDEN NAME <b>EMMA POLK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO <b>219 22 90 47</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE SUPPURATIVE COLITIS</b> DUE TO (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <b>MUCINOUS ADENOCARCINOMA OF RECTUM AND COLON WITH METASTASES</b> DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA AND PULMONARY EDEMA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>  <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 30</b> , 19 <b>67</b> , to <b>APRIL 4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>APRIL 4, 1967</b> , and that death occurred at <b>1500</b> A.M., from causes and on the date stated above.							
22a. SIGNATURE <i>John D. Talbert</i>				22b. DATE SIGNED <b>4/4/67</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-7-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Cherry Wilson</i>		ADDRESS <b>WILSON FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>	
ORLEANS ST. BALTIMORE, MD.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a vault, with in 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

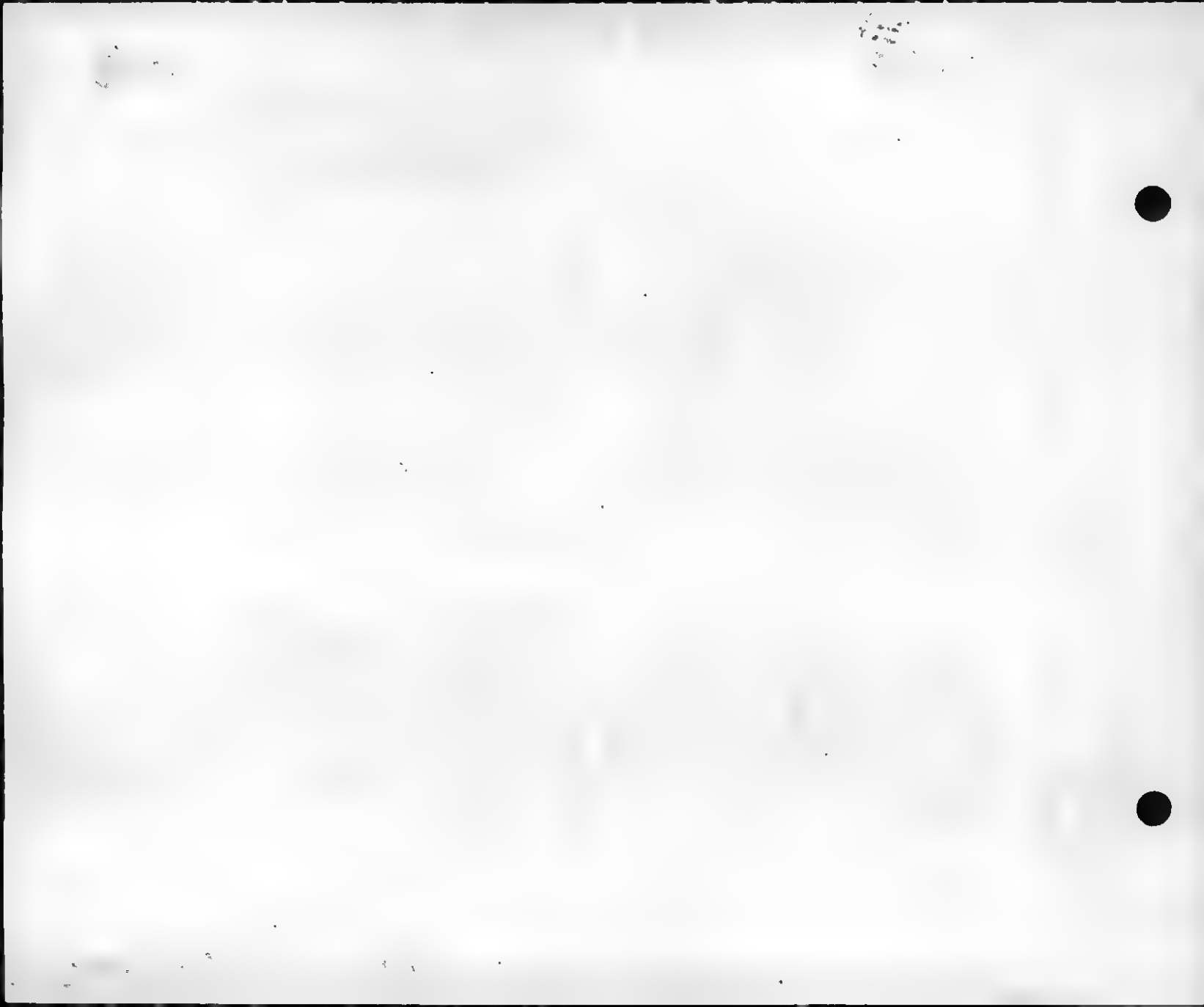
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04738

CERTIFICATE OF DEATH

04738

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>222 N. MARLYN</u>				d. STREET ADDRESS <u>222 N. MARLYN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>L.</u> Last <u>GOFF</u>				4. DATE OF DEATH Month <u>APR.</u> Day <u>23</u> Year <u>1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3, 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs	F UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PAUL GOFF</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE ROUNTON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W. I</u>		16. SOCIAL SECURITY NO. <u>2-16-09-6175</u>		17. INFORMANT <u>MARY GOFF</u>		Address <u>222 N. MARLYN</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>492</u> <u>Acute Coronary Occlusion</u> Due to (b) <u>Indeterminate Consequences of Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.								
22a. SIGNATURE <u>John P. Reilly, M.D.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>John P. Reilly, M.D.</u>		
22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>		
24. FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u>				25a. REC'D BY REGISTRAR <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

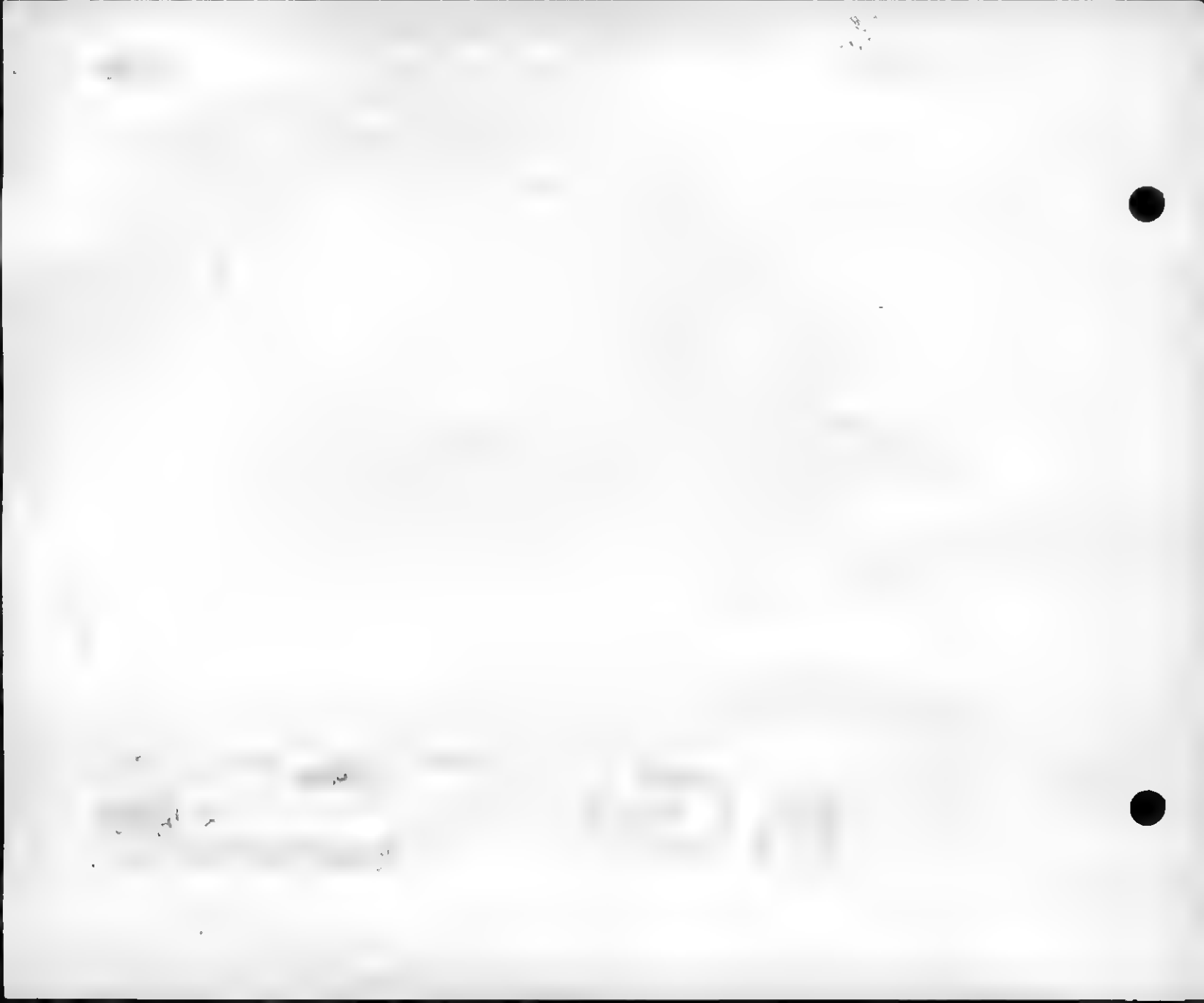
04733

CERTIFICATE OF DEATH

04739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN IT <u>31 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MARtha</u> Middle <u>EVELYN</u> Last <u>GORE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>F.</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-24-12</u>
9a. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post office</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>NORMAN DELL</u>		14. MOTHER'S MAIDEN NAME <u>KELLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16 SOCIAL SECURITY NO <u>218-26-6687</u>	
17 INFORMANT <u>Adm. Notes</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated, retroperitoneal malignant tumor</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-23-</u> , 19 <u>67</u> to <u>4-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/10/67</u> 19 <u>  </u> , and that death occurred at <u>1:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ram K. Chhillar</u>		22b. DATE SIGNED <u>4/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHHILLAR</u>		22d. ADDRESS <u>GREATER BALTIMORE MED. CENTER, BALTIMORE, MD 21224.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Sykesville, Md</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. RECEIVED BY REGISTRAR <u>APR 12 1967</u>	
25b. SIGNATURE <u>John J. Judge</u>		25c. ADDRESS <u>  </u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE HEALTH DEPT.**

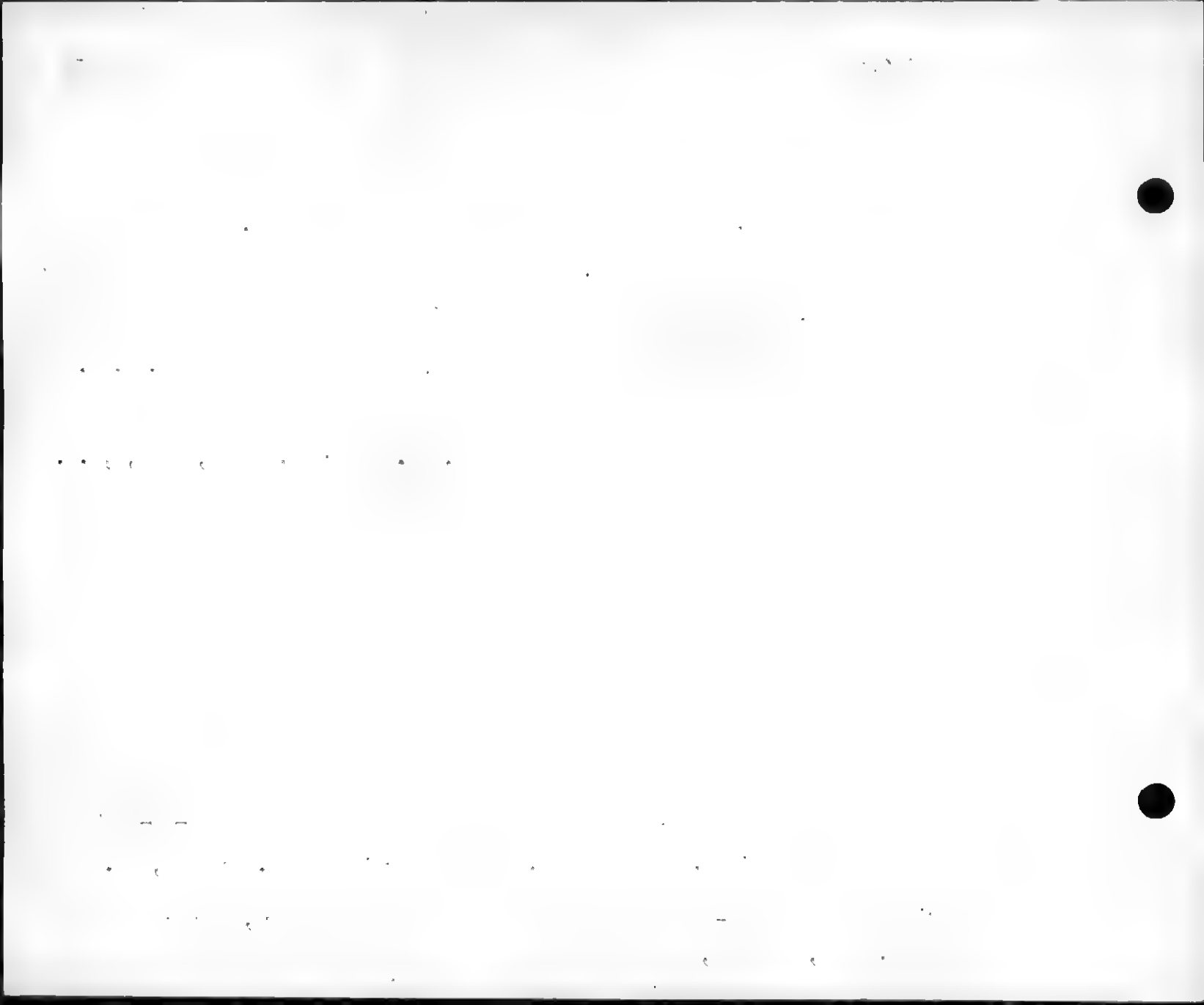
**04740**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**04740**

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c. LENGTH OF STAY IN 1b <b>3 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2628 Marine Ave.</b>		e. STREET ADDRESS <b>2628 Marine Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Sophie</b> Middle <b>G.</b> Last <b>Gover</b>		4 DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/26/69</b>
9 AGE (In years last birthday) <b>57</b> yrs		10 UNDER 1 YEAR Months <b>5</b> Days <b>11</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Massachusetts</b>	
11 BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Jacob Goles</b>		14. MOTHER'S MAIDEN NAME <b>Mary Goles</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>212-22-8690</b>	
17 INFORMANT <b>Husband, Mr. Howard D. Gover, #2#a,b,c,d.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V-DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis</b>		CHIEF MED CAL EXAMINER <input type="checkbox"/> ASSISTANT MED CAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 Mornington Rd., Dundalk, Md. 21222</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis M.D.</b>		DATE SIGNED <b>4-12-1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 14-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland 21224</b>	
24 FUNERAL DIRECTOR <b>John J. Duda, Dundalk, Maryland 21222</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
ADDRESS <b>John J. Duda, Dundalk, Maryland 21222</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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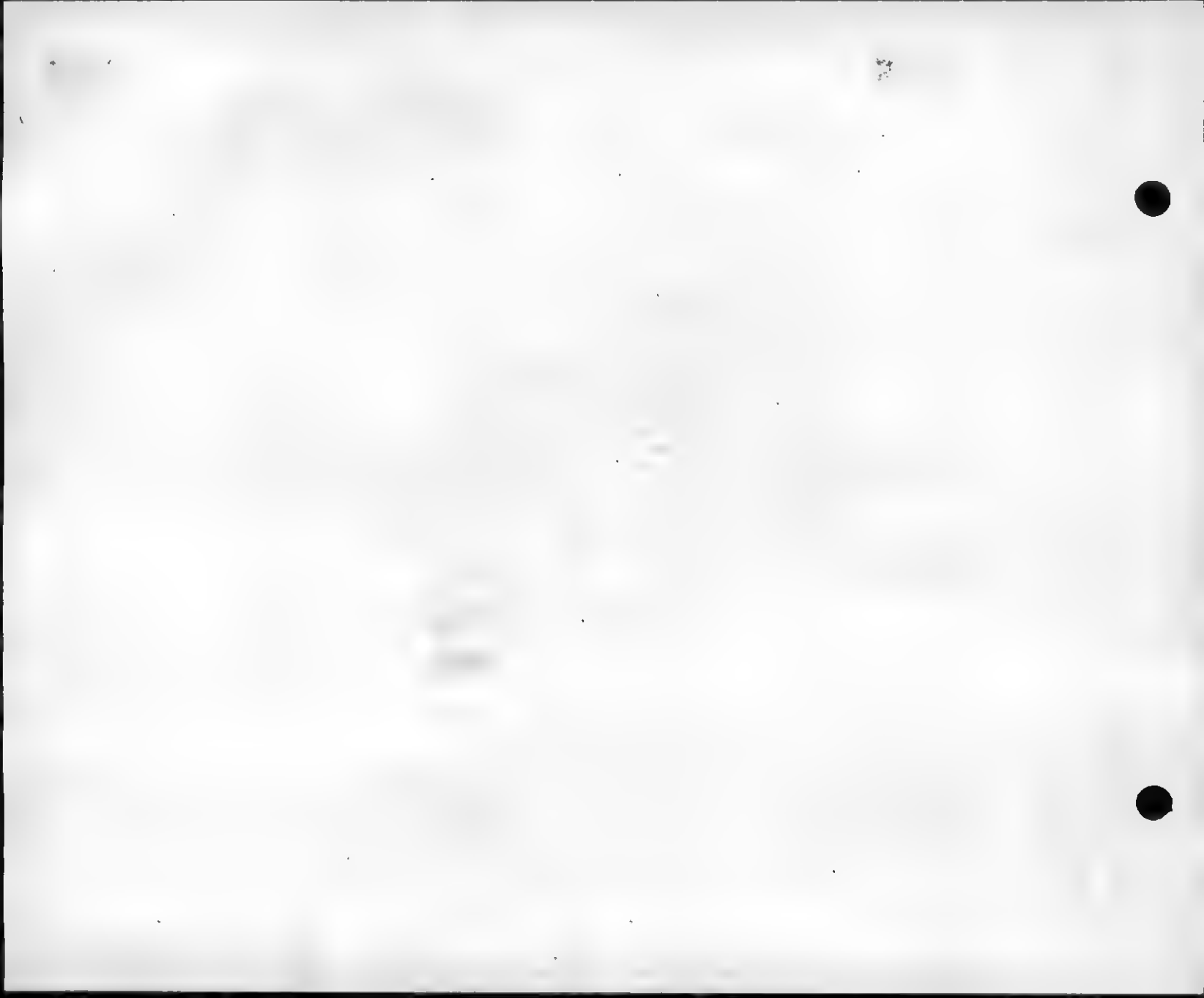
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04741

CERTIFICATE OF DEATH

04741

1 PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
f. STREET ADDRESS <b>Rt 4, Box 421, Christie Rd</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Albert</b> Last <b>Grabenstein</b>		4 DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12.9.99</b>
9 AGE (In years last birthday) <b>67 yrs</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Storekeeper</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Md Cumberland, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Grabenstein</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Logson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes [ ] No [X]) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>705-12-3255</b>	
17 INFORMANT <b>Wm Records</b>		Address <b>Mt. Wilson State Hospital</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO (b) <b>1002.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-16-1967</b> , to <b>4-1-1967</b> , that (I) (we) last saw the deceased alive on <b>4-1-1967</b> , and that death occurred at <b>12:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Wm Newcomer</b>		22b. DATE SIGNED <b>4-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>4-4-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>
24 FUNERAL DIRECTOR <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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25M 1/67

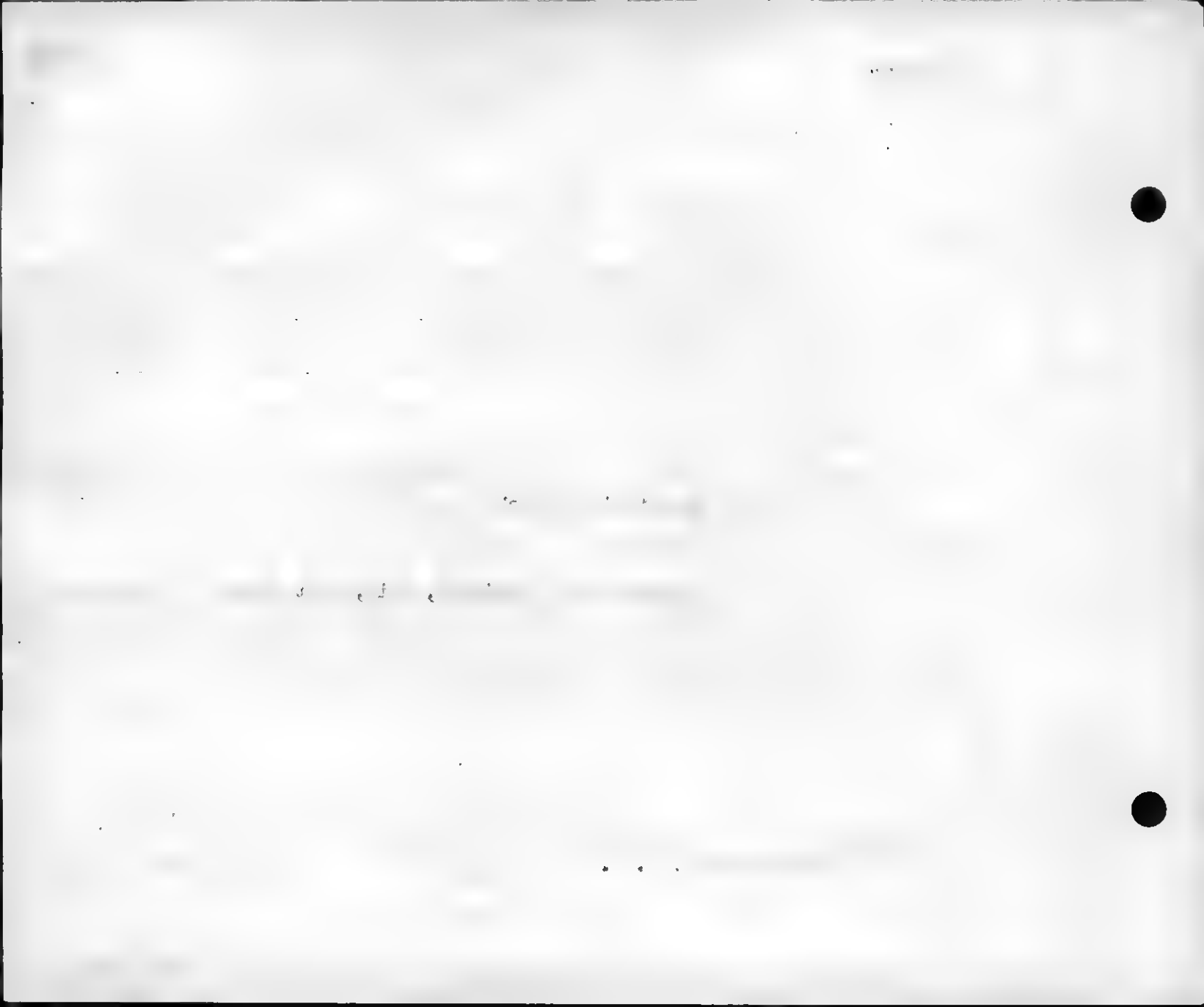
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04742

04742

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> - - MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elliott</b>	
c. LENGTH OF STAY IN 1b <b>141 Days</b>		d. STREET ADDRESS <b>Veterans Administration Hospital</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH HERBERT GRAY</b>		4. DATE OF DEATH Month Day Year <b>APRIL 14 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/95</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. UNDER 1 YEAR Months Days Hours Min	11. UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Elliott, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Gray</b>		14. MOTHER'S MAIDEN NAME <b>Delitha A. Horseman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>220-32-08-36</b>	
17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastasis to Neck</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Squamous Cell Carcinoma, Skin, Left Pinna</b> (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Nov. 25</b> , 19 <b>66</b> , to <b>April 14</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>April 14</b> , 19 <b>67</b> , and that death occurred at <b>9:40 PM</b> from causes and on the date stated above			
22a. SIGNATURE <i>Neilon Neilson</i> M.D.		22b. DATE SIGNED <b>4/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elliott Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Elliott, Maryland</b>
24. FUNERAL DIRECTOR <b>Willoughby Funeral Home East New Market, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

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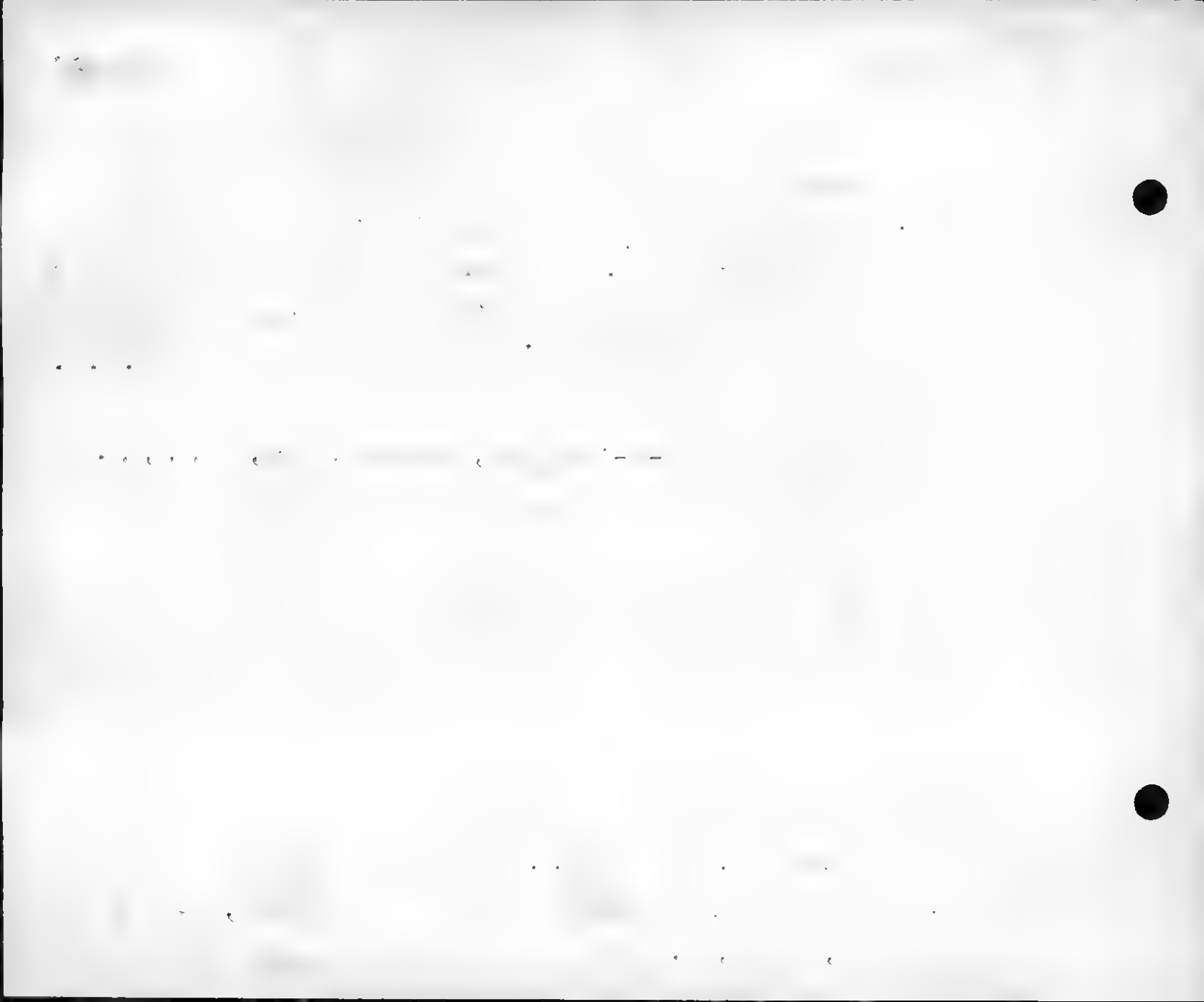
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04743

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN TB <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1915 Armco Way</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>J.</b> Last <b>GREEN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/21/22</b>	9. AGE (In years, r/h/day) <b>44</b> yrs	10. FINDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Installation</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Inc., Petroleum Services</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Rose Boenning</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>Army WWII 216-12-2856</b>		17. INFORMANT <b>Wife, Gertrude L. Green, # 2, a, b, c, d.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Sprigate</b>			M.D. <b>Charles S. Sprigate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
					Address (Street, city, town, or county) <b>April 7, 1967</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<b>Burial</b>		<b>April 10-1967</b>		<b>Oak Lawn Cemetery</b>		<b>Baltimore, Md. 21224</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, Dundalk, Md. 21222</b>				25a. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

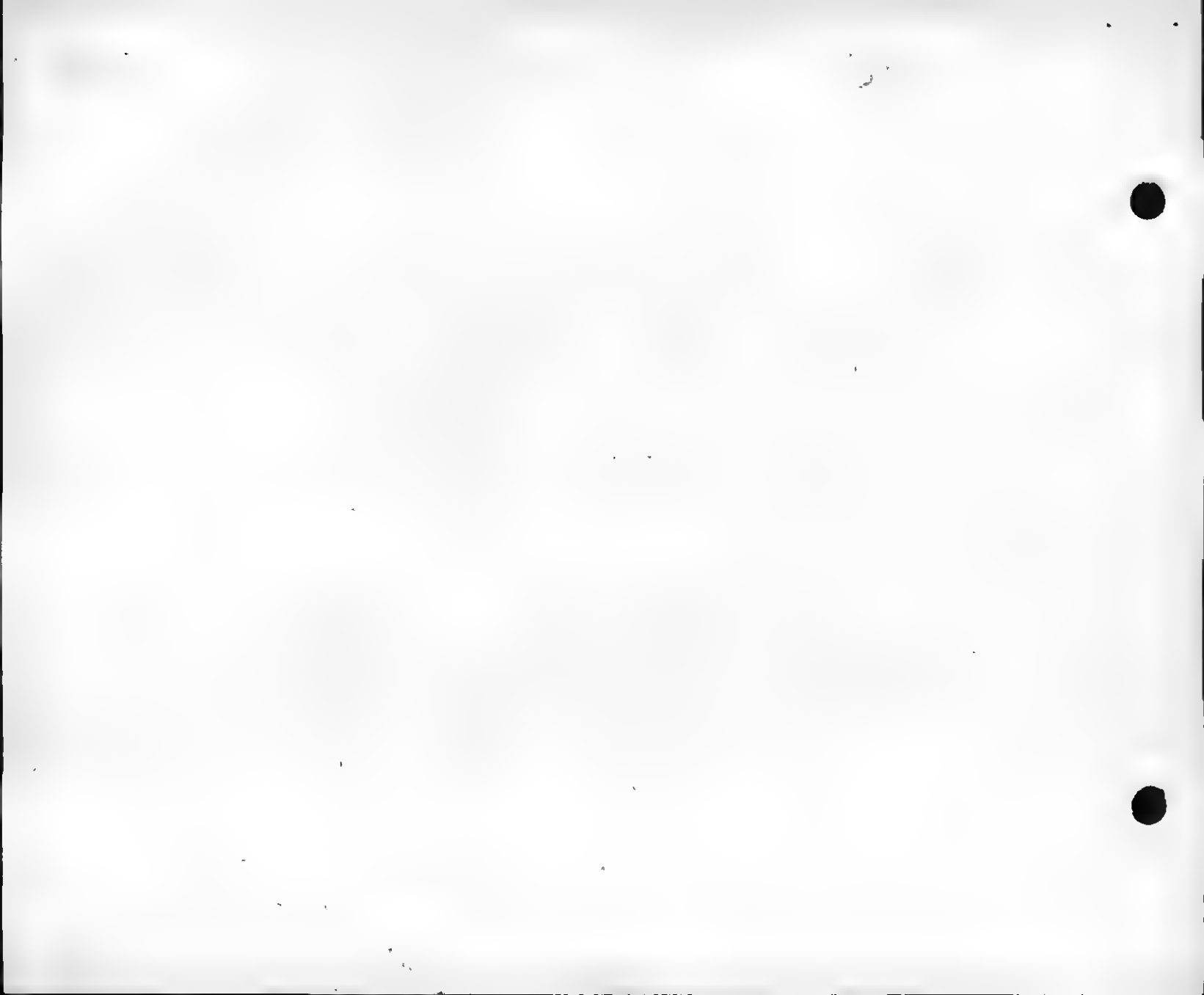
04744

04744

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>St. Joseph Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4900 Belair Rd.</b> d. STREET ADDRESS <b>4900 Belair Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>George Howard GREIF</b>				4 DATE OF DEATH Month Day Year <b>April 26, 1967</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1893</b>	
9 AGE (in years last birthday) <b>63 yrs</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>George Greif</b>			
14. MOTHER'S MAIDEN NAME <b>Anna Martell</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16 SOCIAL SECURITY NO <b>214-18-7434</b>				17 INFORMANT <b>Patient on admission</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of lung.</b> <b>165A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>April 26, 1967</b> , to <b>April 26, 1967</b> , that <b>10</b> (we) last saw the deceased alive on <b>April 26, 1967</b> , and that death occurred at <b>4:40PM</b> , from causes and on the date stated above.							
22a SIGNATURE <b>Melencio Ventura</b> M.D.				22b DATE SIGNED <b>April 27, 1967</b>		22c PHYSICIAN'S NAME (Type) <b>Melencio Ventura, M.D.</b>	
22d ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				22e ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5-1-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR <b>Walter Dabrowski 1005 Dundalk Avenue</b>				25a REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

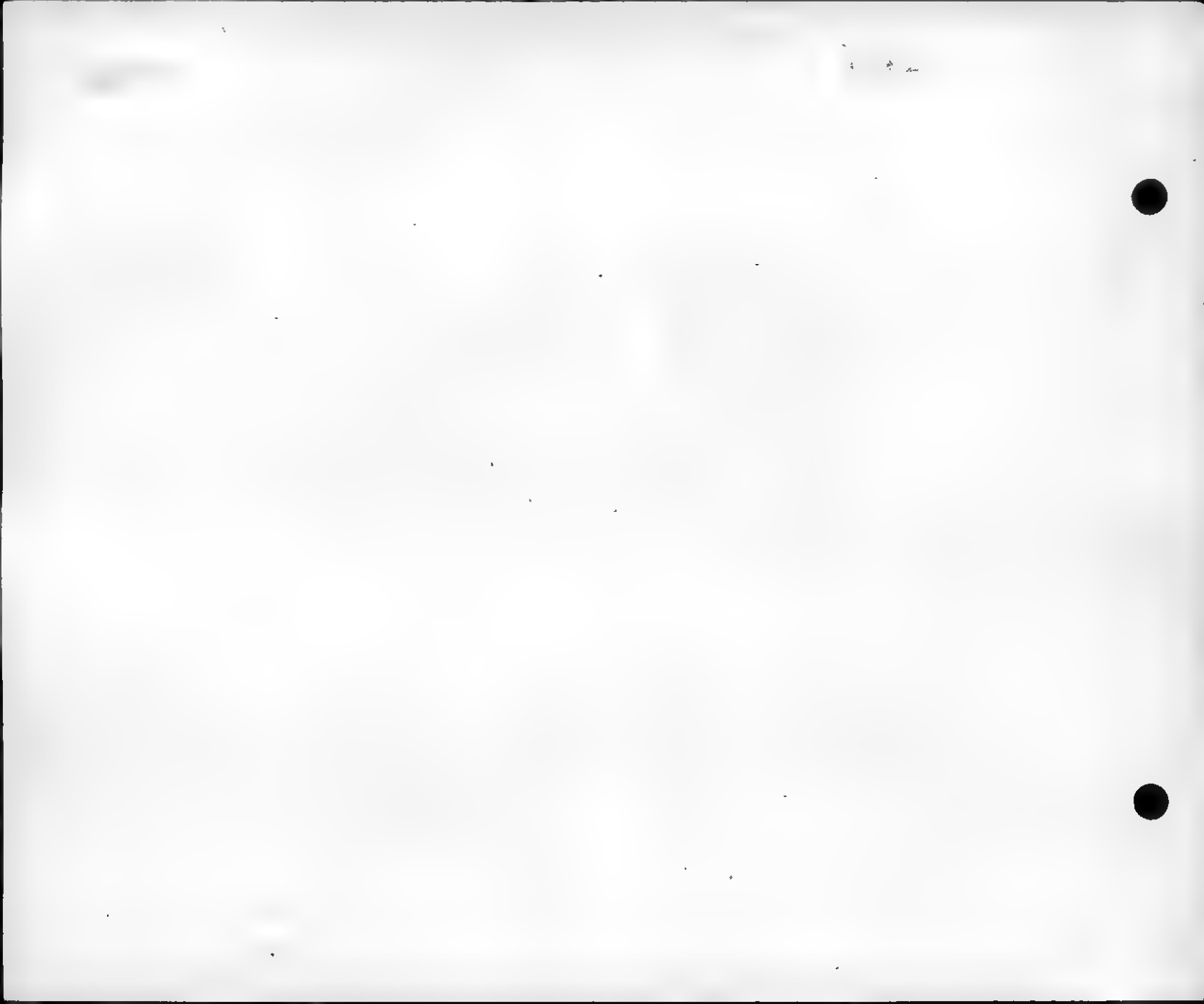
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04745

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04745

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>				c LENGTH OF STAY IN TB			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Melrose Avenue</b>				d STREET ADDRESS <b>Melrose Avenue</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>SIMON</b> Middle <b>F.</b> Last <b>GRIGGS</b>				4 DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Nov 16, 1917</b>	
9 AGE (in years lost, birthday) yrs. <b>49</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Howard Co. School</b>		11 BIRTHPLACE (State or foreign country) <b>Granite, Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13 FATHER'S NAME <b>Elijah Perry Griggs</b>			
14 MOTHER'S MAIDEN NAME <b>Wilhamina Lumpkin</b>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes WW* II</b>			
16 SOCIAL SECURITY NO <b>214-20-1730</b>		17 INFORMANT <b>Herbert Ford</b> <b>Mr. Elijah P. Griggs Woodstock, Md</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> <b>4731</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)					
20c TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>4/6/67</b>					
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b DATE THEREOF <b>4/10/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md</b>		25a REC'D BY REGISTRAR <b>Ark 11 1967</b>	
24 FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave</b>		25b REGISTRAR'S SIGNATURE <b>James J. Jones</b>			



04746

04746

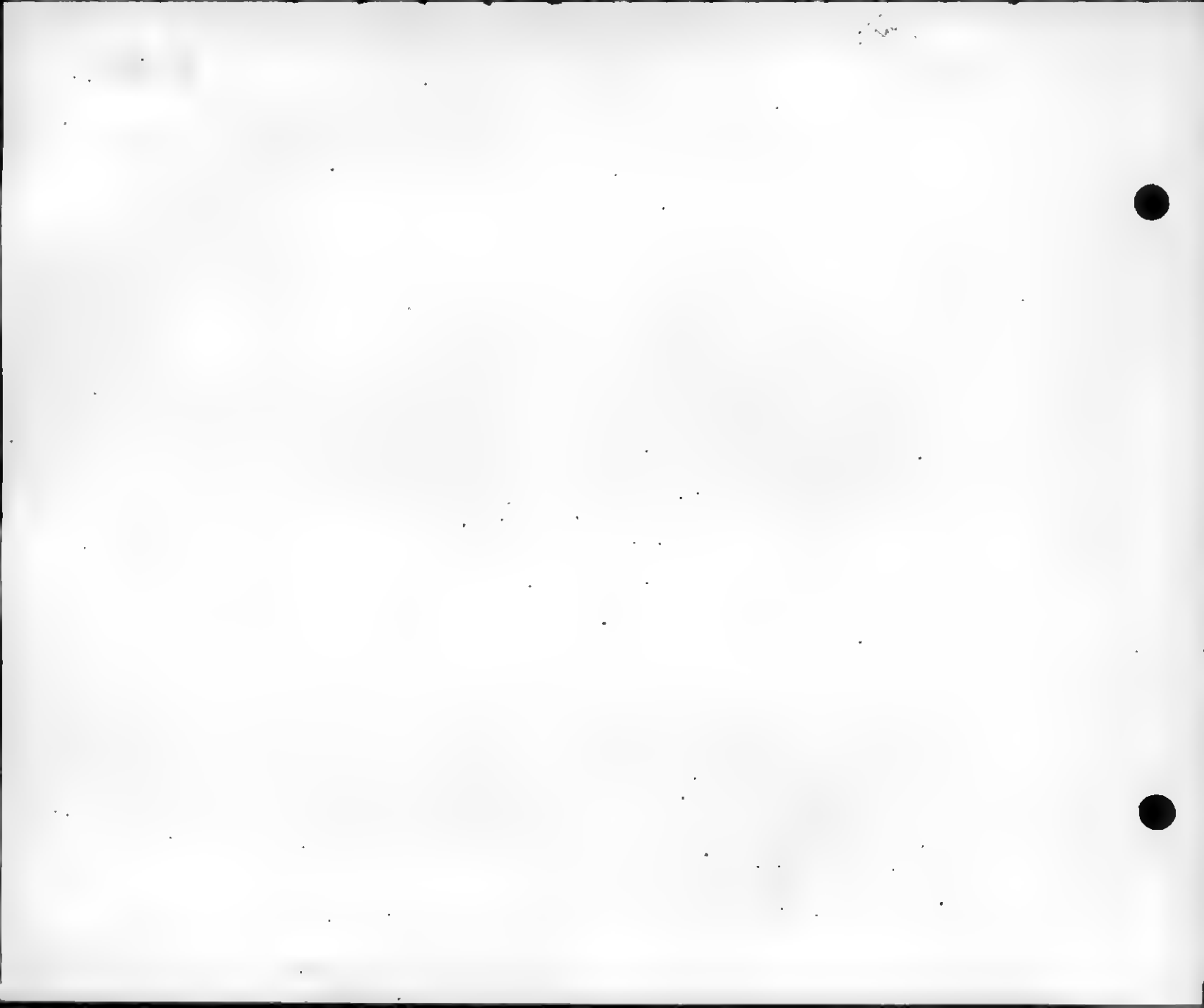
1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1924 Gwynn Oak Ave.</u>		d. STREET ADDRESS <u>1924 Gwynn Oak Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>A.</u> Last <u>Grimmer, Sr.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John G. Grimmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-01-7059</u>	
17. INFORMANT <u>Mr. Raymond A. Grimmer Jr.</u>		Address <u>2243 Searles Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute congestive cardiac failure</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> 19 <u>65</u> to <u>4/10/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>67</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Milton Schleiff</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Milton Schleiff MD</u>		22d. ADDRESS <u>6411 Windsor Mill Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Pk.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury Sr.</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
25a. REC'D BY REGISTRAR <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04747		04747									
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN <u>29 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO. Md.</u>				d. STREET ADDRESS <u>4209 1/2 Old Frederick Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>Frank</u>		Middle <u>J.</u>		Last <u>Groh</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/90</u>		9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN - BAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Frank Groh</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Reese Ring</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mary Hipsley</u>		Address <u>4209 1/2 Old Frederick Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Metastatic Squamous Carcinoma Mandible</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASHD &amp; Atrial Fibrillation; Diabetes Mellitus</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>67</u> , to <u>4/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Miguel R. Alonso</u>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Miguel R. Alonso</u>						22b. DATE SIGNED <u>April 8, 1967</u>					
22d. ADDRESS <u>Greater Balto. Med Center</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>April 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem. BALTO. Md.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>			
24. FUNERAL DIRECTOR <u>G. TRUNAN Schnab. 3512 Fred. Ave.</u>				ADDRESS <u>BALTO. Md.</u>		25a. REC'D BY REGISTRAR <u>APR 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04748

04748

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY in lb <b>121 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1720 CLARKSON STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>EMANUEL</b> Middle <b>EMIL</b> Last <b>GROSS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/97</b>
9. AGE (in years last birthday) <b>69</b> yrs		10. IF UNDER YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>	11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EMANUEL GROSS</b>	
14. MOTHER'S MAIDEN NAME <b>MARY KING</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>	
16. SOCIAL SECURITY NO. <b>218 18 95 39</b>		17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL FEMORAL ARTERY OCCLUSION, ACUTE</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>A</b> (this hospital) attended the deceased from <b>DECEMBER 16, 1966</b> to <b>APRIL 16, 1967</b> , that <b>A</b> (we) last saw the deceased alive on <b>APRIL 16, 1967</b> , and that death occurred at <b>8:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Louis C. Breschi</b>		22b. DATE SIGNED <b>4/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS C. BRESCHI, M. D.</b>		22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Apr. 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Wm. J. Sore</b>		25a. REC'D BY REGISTRAR <b>APR 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Phyllis Under</b>		25c. REGISTRAR'S SIGNATURE <b>Phyllis Under</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04749

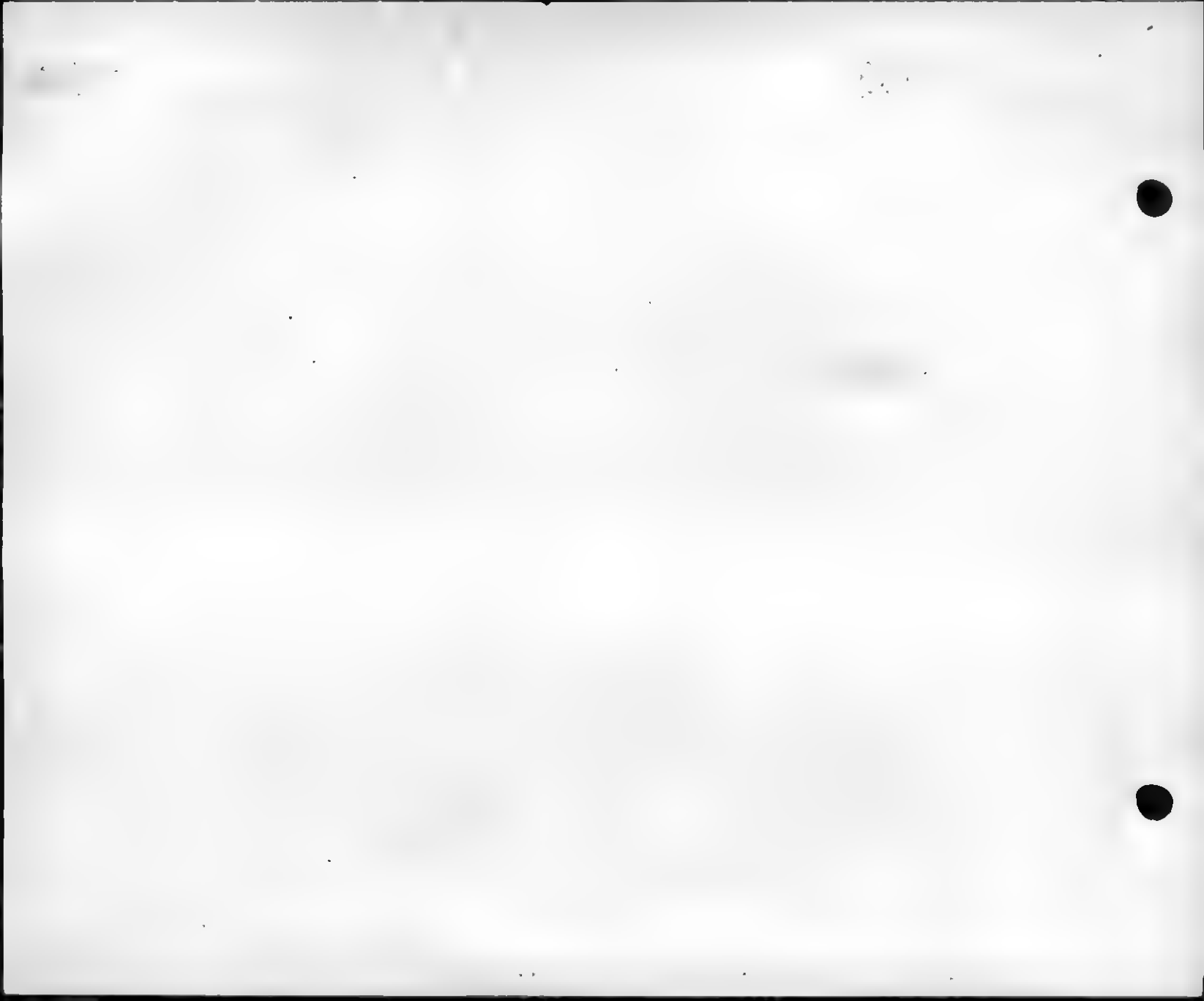
**CERTIFICATE OF DEATH**

04749

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>				c. LENGTH OF STAY in 1b <u>21208</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp</u>				d. STREET ADDRESS <u>6948 Marsue Drive</u>			
3. NAME OF DECEASED (Type or print) <u>LEON H GROSSMAN</u>				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-01</u>	
9. AGE (In years last birthday) <u>66</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INS. SALESMAN</u>		11. BIRTHPLACE (County & State or foreign country) <u>ROMANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JACOB GROSSMAN</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>214-03-3003</u>				17. INFORMANT <u>Hosp. Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Convulsions</u> DUE TO <u>Cardioma of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardioma of lungs</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-16-1967</u> , to <u>4-17-1967</u> , that (I) (we) last saw the deceased alive on <u>4-17-1967</u> , and that death occurred at <u>3:00AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Gracita R. Parricio</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Gracita R. Parricio</u>	
22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>				22e. MED. DIRECTOR <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN</u>		23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04750**

**CERTIFICATE OF DEATH**

**04750**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>910 Fairway Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>DORA HAHN</b> First Middle Last <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Houswife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>4. DATE OF DEATH</b> <b>April 11, 1967</b> Month Day Year <b>9. AGE</b> (in years last birthday) <b>72</b> yrs <b>F UNDER 1 YEAR</b> Months Days Hours Min <b>IF UNDER 24 HRS</b>				
<b>13. FATHER'S NAME</b> <b>William Post</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Caroline</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Address <b>Mrs. Doris Haslbeck, 910 Fairway Dr. 21204</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Artery Disease</b> (c) <b>Hypertension Caused Renal Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>PART I OTHER SIGNIFICANT CONDITIONS</b> CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				<b>21. I certify that (I) (ths hospital) attended the deceased from 5/28, 1966 to 4/11, 1967, that (I) (we) last saw the deceased alive on 3/27, 1967, and that death occurred at 3 P.M. from causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>Charles F. O'Donnell</i> <b>22b. DATE SIGNED</b> <b>4/13/67</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Charles F. O'Donnell</b> <b>22d. ADDRESS</b> <b>7501 York Road, Baltimore, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4-14-1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Pauls Lutheran Cem.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Baltimore, Maryland</b>		<b>25a. RECD BY REGISTRAR</b> <b>APR 17 1967</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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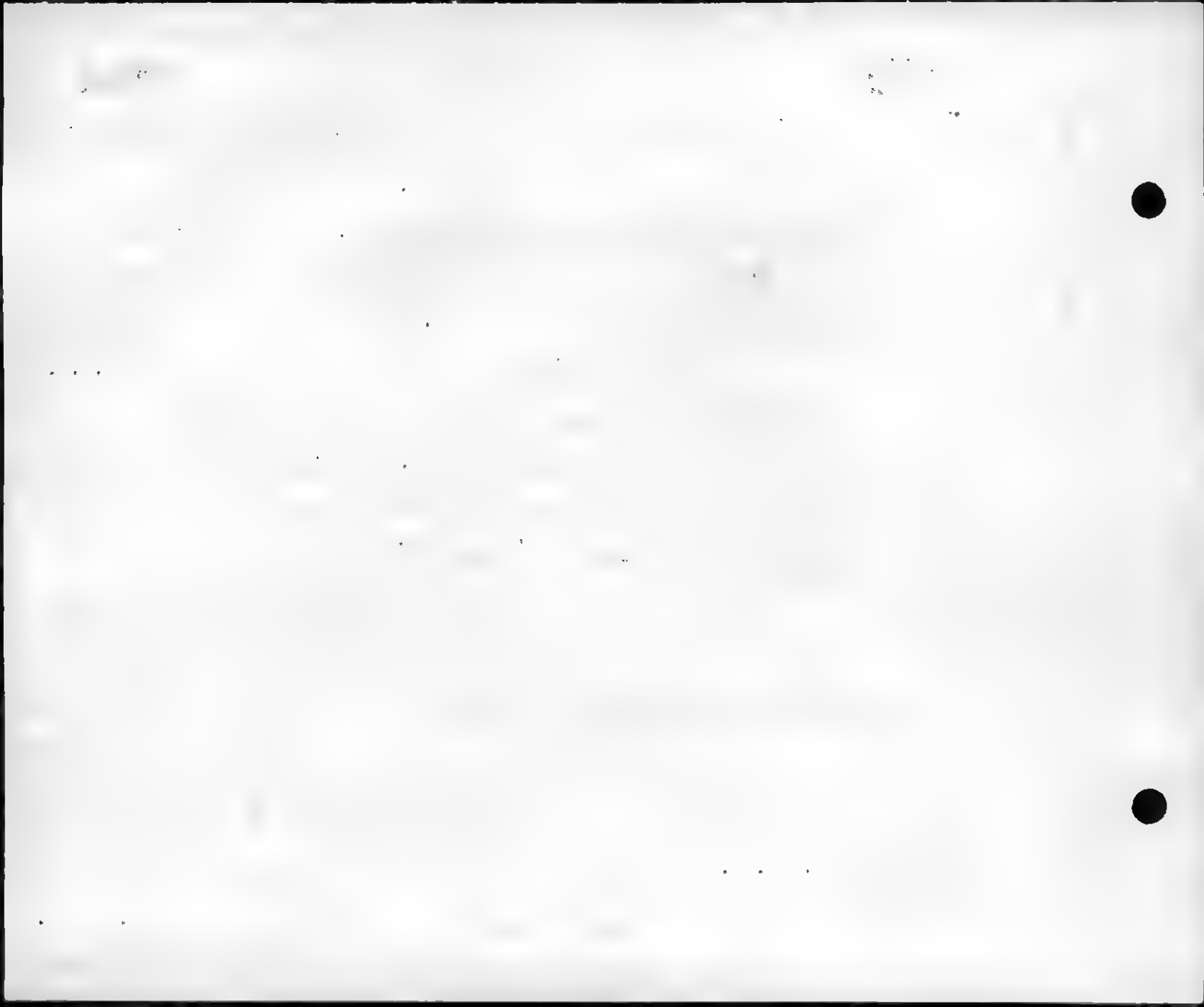
MD  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04751

CERTIFICATE OF DEATH

04751

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase (Rural)</b>			c. LENGTH OF STAY IN 1b <b>10yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 296 Bird River Beach Road</b>				d. STREET ADDRESS <b>Box 296 Bird River Beach Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>I</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-31-1915</b>		9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>welding</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martins</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Mitchell</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Klien</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-18-9504</b>		17. INFORMANT Address <b>21220</b> <b>Mr David K. Hall Box 296 Bird River Beach</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Benign Breast Cancer</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>metastatic Cancer of the breast</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Wm. A. Rodger</b>				22b. DATE SIGNED <b>4/25/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Wm. A. Rodger</b>	
22d. ADDRESS <b>835 Eastern Avenue</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Lassell Funeral Home 7401 Boleyn Road</b>				25a. REC'D BY REGISTRAR <b>APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04752

CERTIFICATE OF DEATH

04752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>25 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE 1, BOX 331</b>	
3 NAME OF DECEASED (Type or print) First <b>FOSTER</b> Middle <b>REED</b> Last <b>HALL</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>NOVEMBER 2, 1923</b>
9a. AGE (In years last birthday) <b>43</b> yrs		9b. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRAFTSMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP YARD</b>	
11. BIRTHPLACE (County & State or foreign country) <b>PIKE COUNTY, KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES HALL</b>		14. MOTHER'S MAIDEN NAME <b>OIA WRIGHT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>405 22 25 66</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MENINGITIS, PNEUMOCOCCUS</b> DUE TO (b) <b>BRAIN ABSCESS, LEFT OCCIPITAL LOBE</b> DUE TO (c) <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b):			INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b> <b>RECENT</b> <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CRANIOTOMY, RECENT. TRACHEOSTOMY, RECENT</b>			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>3/13/67</b> , 19__, to <b>4/7/67</b> , 19__, that (X) (we) last saw the deceased alive on <b>4/7/67</b> , 19__, and that death occurred at <b>7:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>4/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MC CULLY FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>



10

1

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04753 CERTIFICATE OF DEATH 04753

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore, Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b>				c. LENGTH OF STAY IN 1b <b>3mons +</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Towson Nursing Home, 111 West Rd</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>C</b> Last <b>Hanson</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3, 1879</b>	
9. AGE (In years last birthday) <b>88 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>accountant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William H. Hanson</b>				14. MOTHER'S MAIDEN NAME <b>Sugars</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>705-03-484</b>			
17. INFORMANT <b>CHARLES R. HANSON - 2111 West Rd</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate gland with generalized metastases</b> DUE TO (b) <b>3 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>1950</b> to <b>March</b> , 1967, that (I) <del>last</del> saw the deceased alive on <b>March 13</b> , 1967, and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William T. Traband</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLARD T. TRABAND JR</b>				22d. ADDRESS <b>1811 North Rolling Rd. BALTIMORE, MD. 21207</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery - Baltimore Md</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Ellsworth ARMA - 466 Liberty Hgts Ave</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>APR 19 1967</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

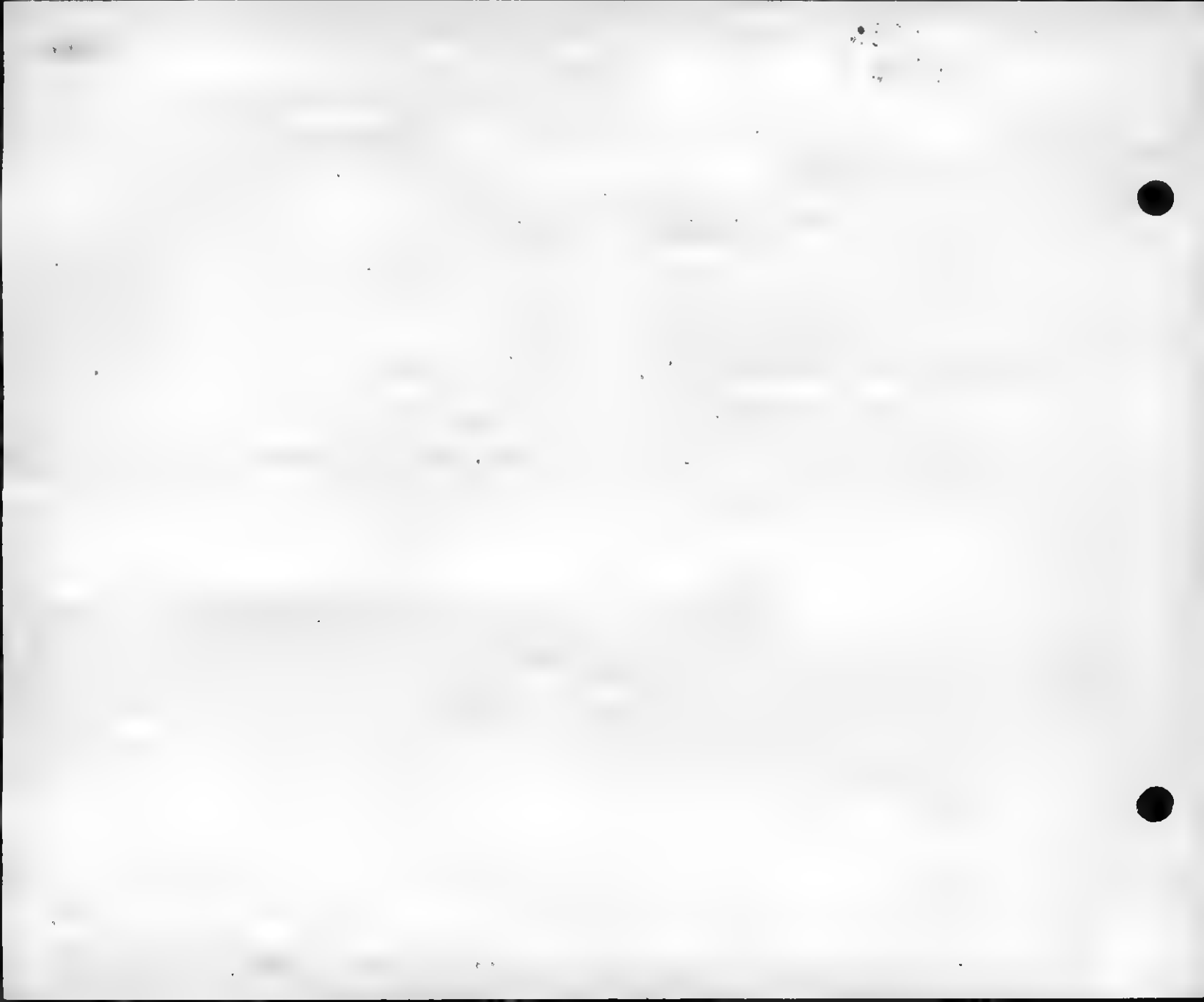
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04754

CERTIFICATE OF DEATH

04754

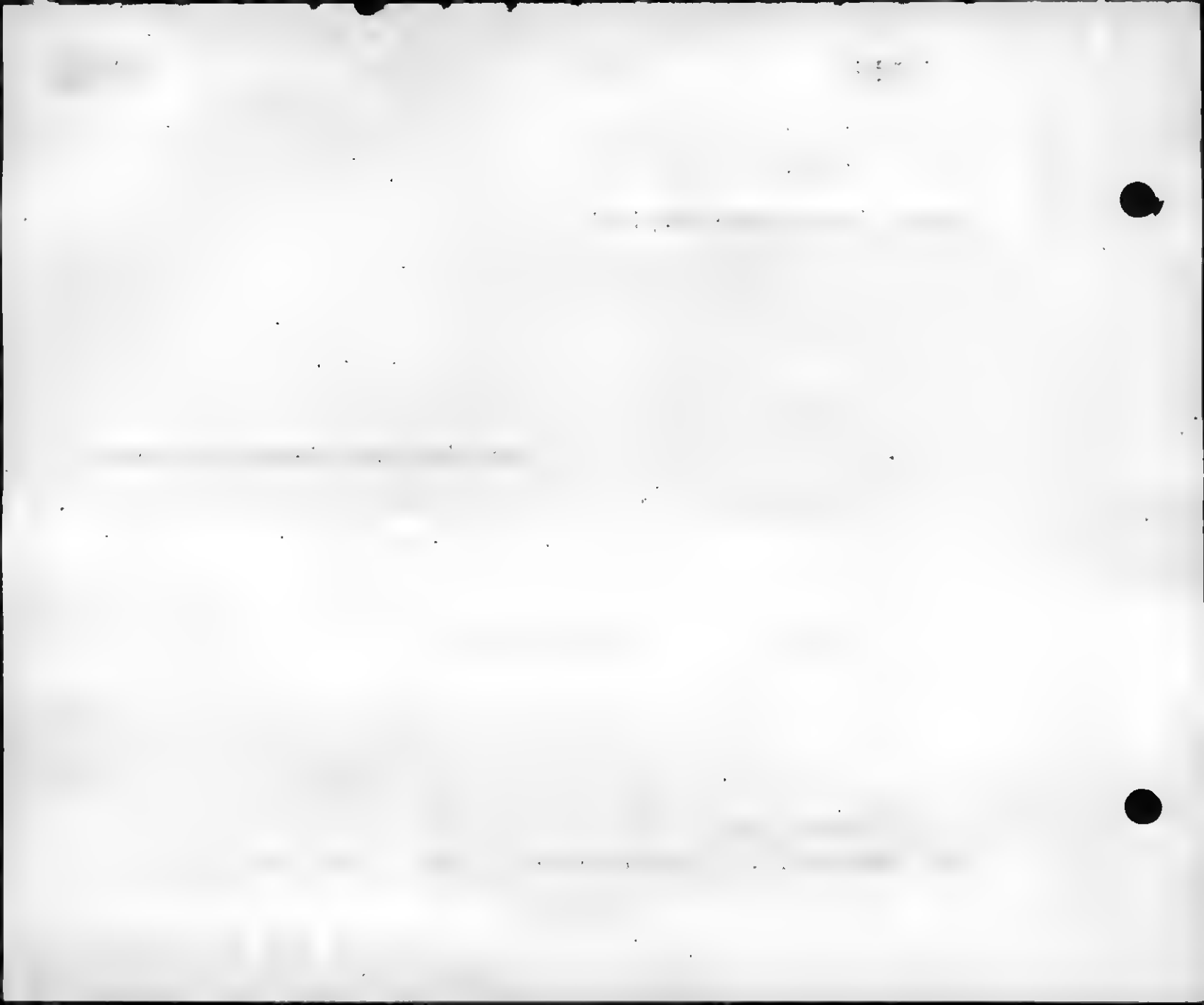
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Ba Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		e. STREET ADDRESS <u>2111 Southland Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Edwin</u> First <u>ANN</u> Middle <u>HANSSON</u> Last <u>1-HANSSON</u>		4 DATE OF DEATH <u>4</u> Month <u>10</u> Day <u>19</u> Year <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-16-83</u>
9a. AGE (In years last birthday) <u>83</u> yrs		9b. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa Water &amp; Power Co.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Andrew Hansson</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-2040</u>	
17. INFORMANT <u>Mrs. Anna T. Hansson</u>		Address <u>2111 Southland Rd</u>	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/60</u> , 19 <u>60</u> to <u>4/4/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/4/67</u> , 19 <u>67</u> , and that death occurred at <u>9 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>William Schenkoff</u>		22b. DATE SIGNED <u>4/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William Schenkoff</u>		22d. ADDRESS <u>6100 W. Woodlawn</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or town) (County) (State) <u>Woodlawn Md.</u>
24. FUNERAL DIRECTOR <u>G. Howard Strong 3207 W. North Ave.,</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN ID <b>2 years.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Shady Side</b> d. STREET ADDRESS <b>Avery Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HARDUM Mabel</b>			First Middle Last <b>HARDIN</b>			4. DATE OF DEATH Month Day Year <b>4 / 13 / 1967</b>			5. SEX <b>F.</b>		
6. COLOR OR RACE <b>White.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>10/30/1908</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edwin Head.</b>						14. MOTHER'S MAIDEN NAME <b>Mary Martin.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records, Mount Wilson State Hospital</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>0021</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post. left Pneumonectomy</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Tuberculosis</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>4-7</b> , 19 <b>65</b> , to <b>4-13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-13</b> , 19 <b>67</b> , and that death occurred at <b>8:45</b> A.M., from the causes and on the date stated above. 22a. SIGNATURE <b>Wm. Newcomer</b> 22b. DATE SIGNED <b>4-13-67</b> 22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b> 22d. ADDRESS <b>Mount Wilson, Maryland</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>April 15/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Woodfield</b> 23d. LOCATION (City, town or county) (State) <b>Galesville Md.</b> 24. FUNERAL DIRECTOR <b>TA Hackett</b> 25a. REC'D BY REGISTRAR <b>APR 18 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

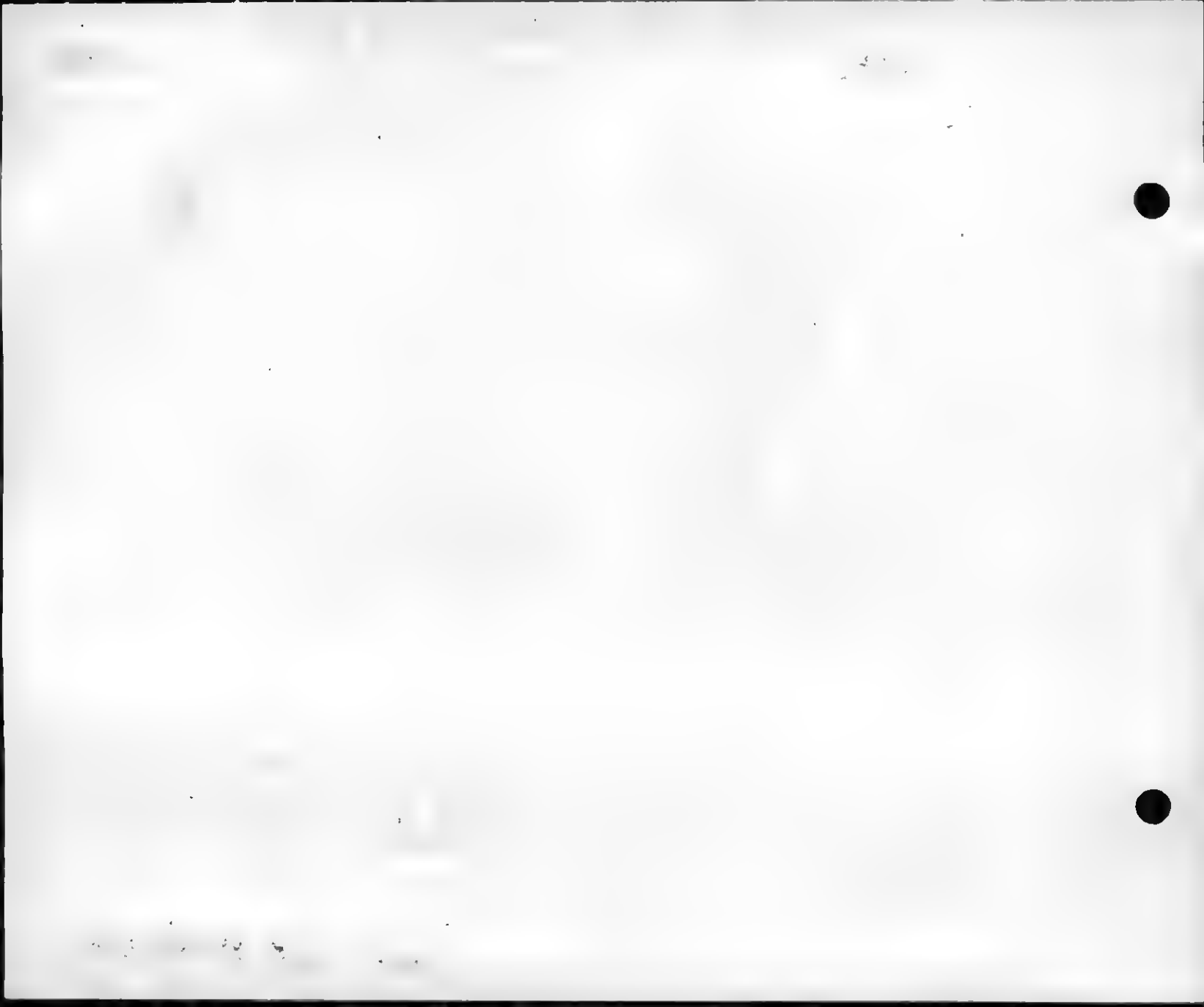
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04756

CERTIFICATE OF DEATH

04756

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Florida</u> c. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>				d. STREET ADDRESS <u>7403 - 46th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Nare</u>				4 DATE OF <u>April</u> 7 19 <u>67</u>			
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>October 12, 1878</u>	9 AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William Bowen</u>				14 MOTHER'S MAIDEN NAME <u>Margaret Lase</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>220-54-63449</u>		17 INFORMANT <u>Records of Md. Masonic Home</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Cerebrovascular accident</u> 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 hypertension Bronchopneumonia</u> DUE TO (c) <u>2 Embolus - 4 - fracture hip</u>						INTERVAL BETWEEN ONSET AND DEATH <u>approx 2 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 11, 1965</u> , to <u>April 7, 1967</u> that (I) (we) last saw the deceased alive on <u>April 7, 1967</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James H. Hamed</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED</u>				22d. ADDRESS <u>MASONIC HOME</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DROID RIDGE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>	
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks TOWSON</u>				25a. REC'D BY REGISTRAR <u>APR 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

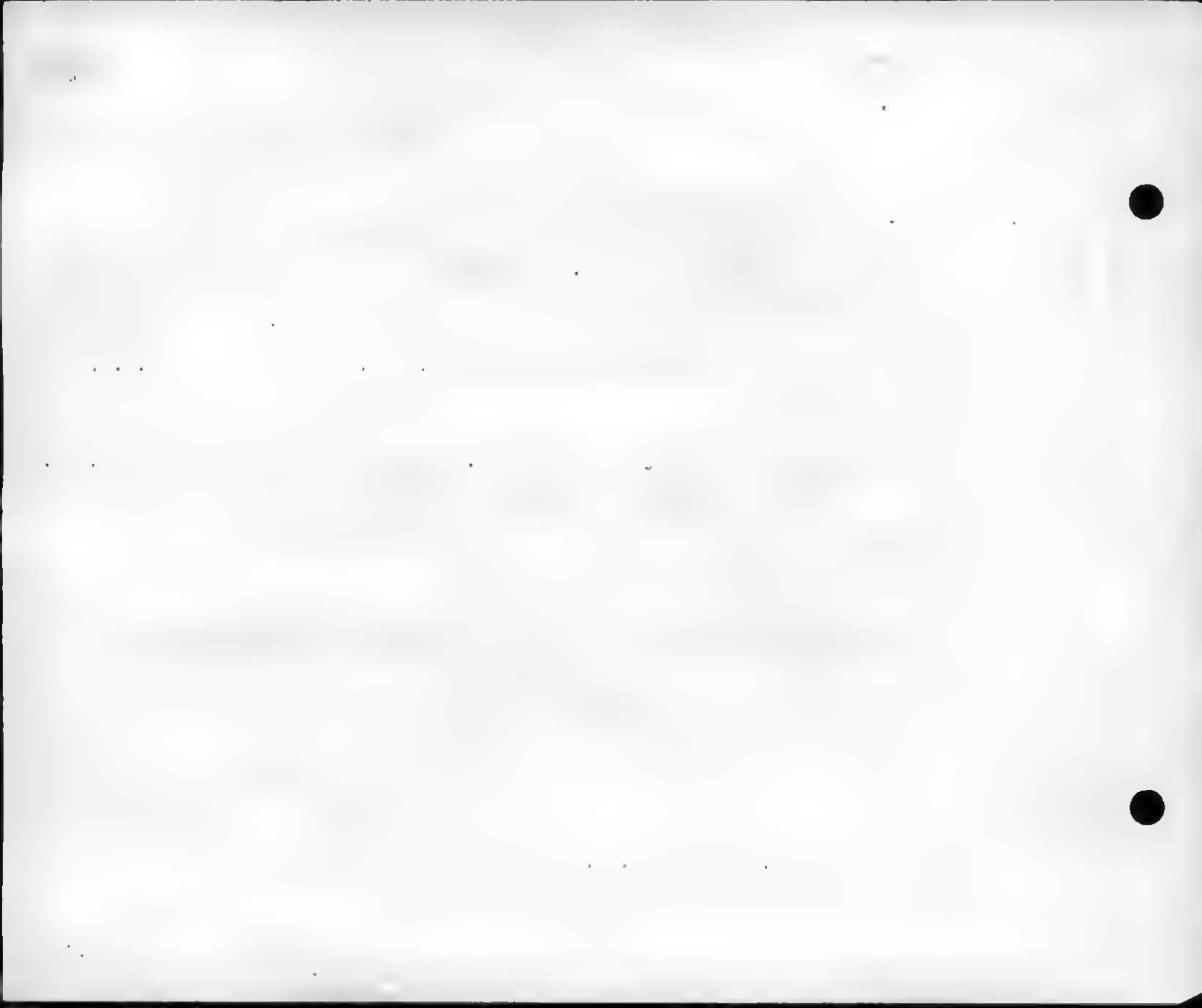
04757

CERTIFICATE OF DEATH

04757

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>8623 WENDELL AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>G.</b> Last <b>HARTMAN</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>9/21/91</b>
9 AGE (In years last birthday) <b>75</b> yrs.		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE COUNTY</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>ROSSVILLE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>CHARLES HARTMAN</b>		14 MOTHER'S MAIDEN NAME <b>HILDA MILLER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO. <b>213 10 85 75</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CEREBRAL EDEMA AND PULMONARY EDEMA</b>		19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (X) (this hospital) attended the deceased from <b>4/7/67</b> , 19__, to <b>4/10/67</b> , 19__, that (X) (we) last saw the deceased alive on <b>4/10/67</b> , 19__, and that death occurred at <b>6:30PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>J. D. Talbert</b>		22b DATE SIGNED <b>4/11/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b DATE THEREOF <b>4-13-1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <b>LASSAHN FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>APR 12 1967</b>	
25b REGISTRAR'S SIGNATURE <b>W. M. Judge</b>		25c ADDRESS <b>BELAIR ROAD, BALTIMORE, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

04758

04758

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c LENGTH OF STAY IN 1b <u>4 1/2 YRS.</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		d STREET ADDRESS <u>303 main ST</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <u>303 main Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Nannie Ann Heath</u>		4 DATE OF DEATH <u>April 19, 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>AUG. 26, 1902</u>
9 AGE (In years last birthday) <u>64 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR IND. STRY <u>Laundry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Drakes Branch, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Spencer Lee</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Dunvill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-20-4563</u>	
17. INFORMANT <u>James W. Heath</u>		Address <u>303 main ST</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY congestion</u> DUE TO (b) <u>HAEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Nephritis-Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 days</u> <u>3 mos</u> <u>?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>June 19, 1950</u> to <u>April 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1967</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>William C. Wade</u>		22b. DATE SIGNED <u>April 19, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		22d ADDRESS <u>140 Oak Hill Dundalk 22, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-23-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>		25a REC'D BY REGISTRAR <u>APR 24 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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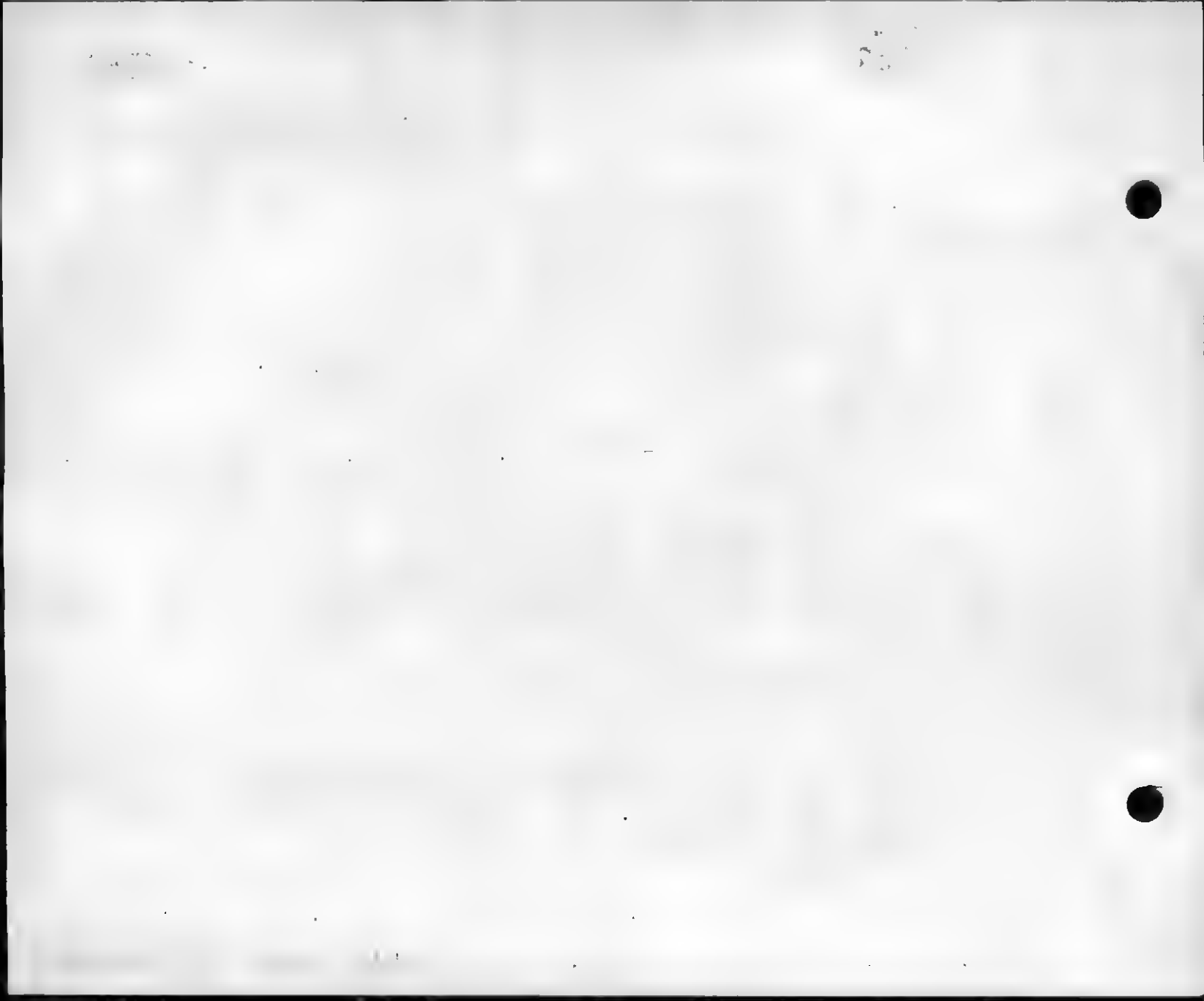
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TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04759 CERTIFICATE OF DEATH 04759

1. PLACE OF DEATH a. COUNTY Balto.				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland				b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b / Weeks				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give address) Dulaney-Towson Nursing Home, 111 West Rd.								d. STREET ADDRESS 501 Garnett Road			
3. NAME OF DECEASED (Type or print) First Middle Last Martha Ruth Helbruck				4. DATE OF DEATH Month Day Year 4 29 1967				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1897		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) E. St. Louis, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel William Wright Gullion				14. MOTHER'S MAIDEN NAME Mary Jane Garrish							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 345-24-9168		17. INFORMANT Mrs. Jeannette M. Collins 501 Garnett Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH Months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 4-27-67, and that death occurred at 3:10 PM, from the causes and on the date stated above.											
22a. SIGNATURE Richard K Gundry M.D.								22b. DATE SIGNED 4-29-67			
22c. PHYSICIAN'S NAME (Type) Richard K Gundry								22d. ADDRESS 2 W University Pkwy, 21218			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery				23d. LOCATION (City, town or county) (State) St. Clair, Illinois			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DATE MAY 2 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			



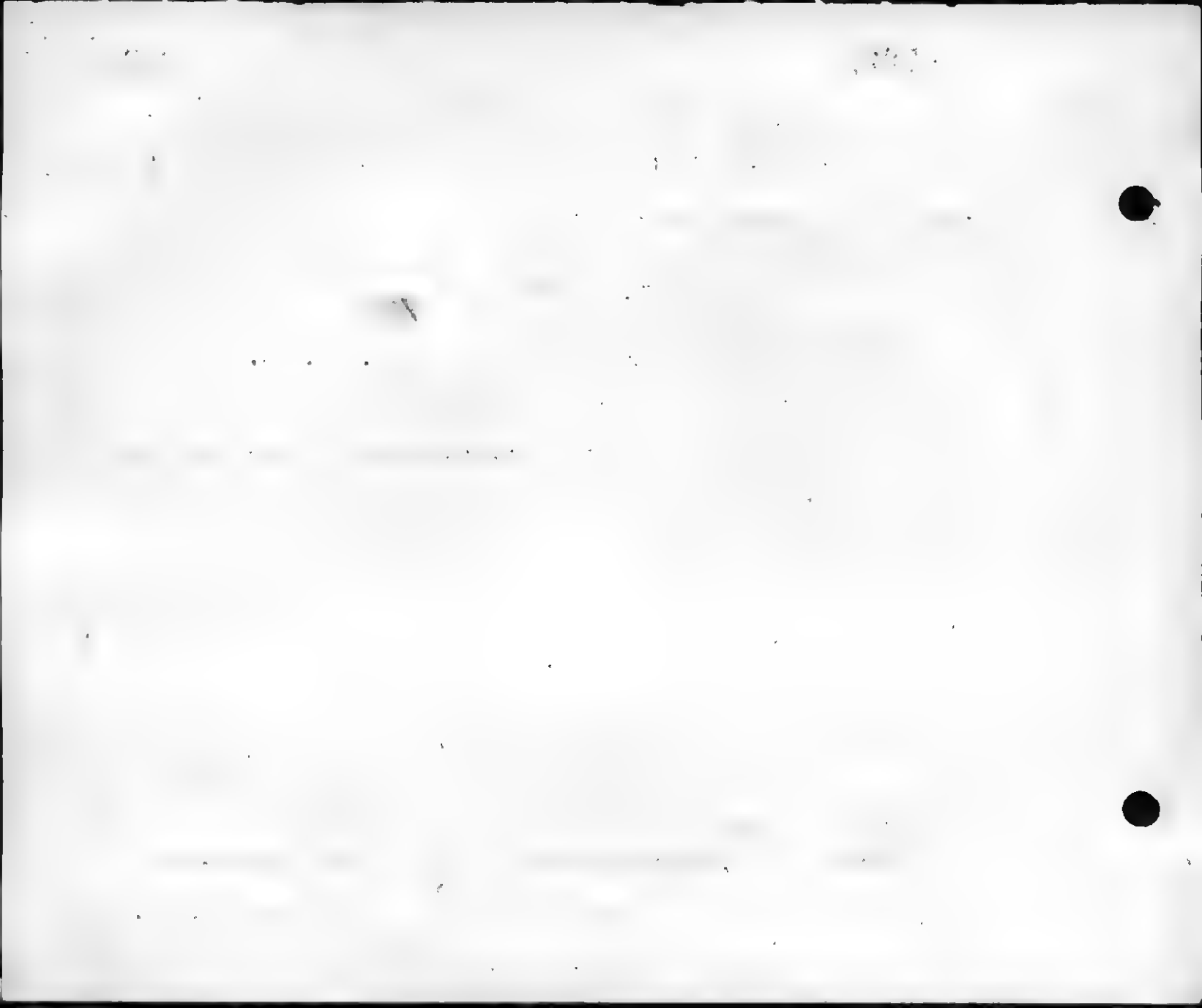


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>1 yr 8 1/2 mo</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CECIL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CONOWINGO RURAL</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JOHN ALEXANDER HENDERSON</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>4 12 1967</b>	
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>NEGRO</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/5/1900</b>
<b>9. AGE</b> (In years last birthday) <b>66 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. <b>66</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>General</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Balt. Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>AMOS HENDERSON</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>BLANCHE HALL</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-10-9447</b>	
<b>17. INFORMANT</b> <b>Records, Mount Wilson State Hospital</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic obstructive airway disease</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <b>YEARS</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>27 July</b> , 1965, <b>to</b> <b>12 April</b> , 1967, <b>that (I) (we) last saw the deceased alive on</b> <b>12 April</b> 1967, <b>and that death occurred at</b> <b>4 P.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Wm. Newcomer</b>		<b>22b. DATE SIGNED</b> <b>12 April 67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wm. Newcomer, M.D., Superintendent</b>		<b>22d. ADDRESS</b> <b>Mount Wilson, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4/17/67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Zoar Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Conowingo, Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Richard L. Goodie</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 17 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		<b>25c. ADDRESS</b> <b>Rising Sun, Md.</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

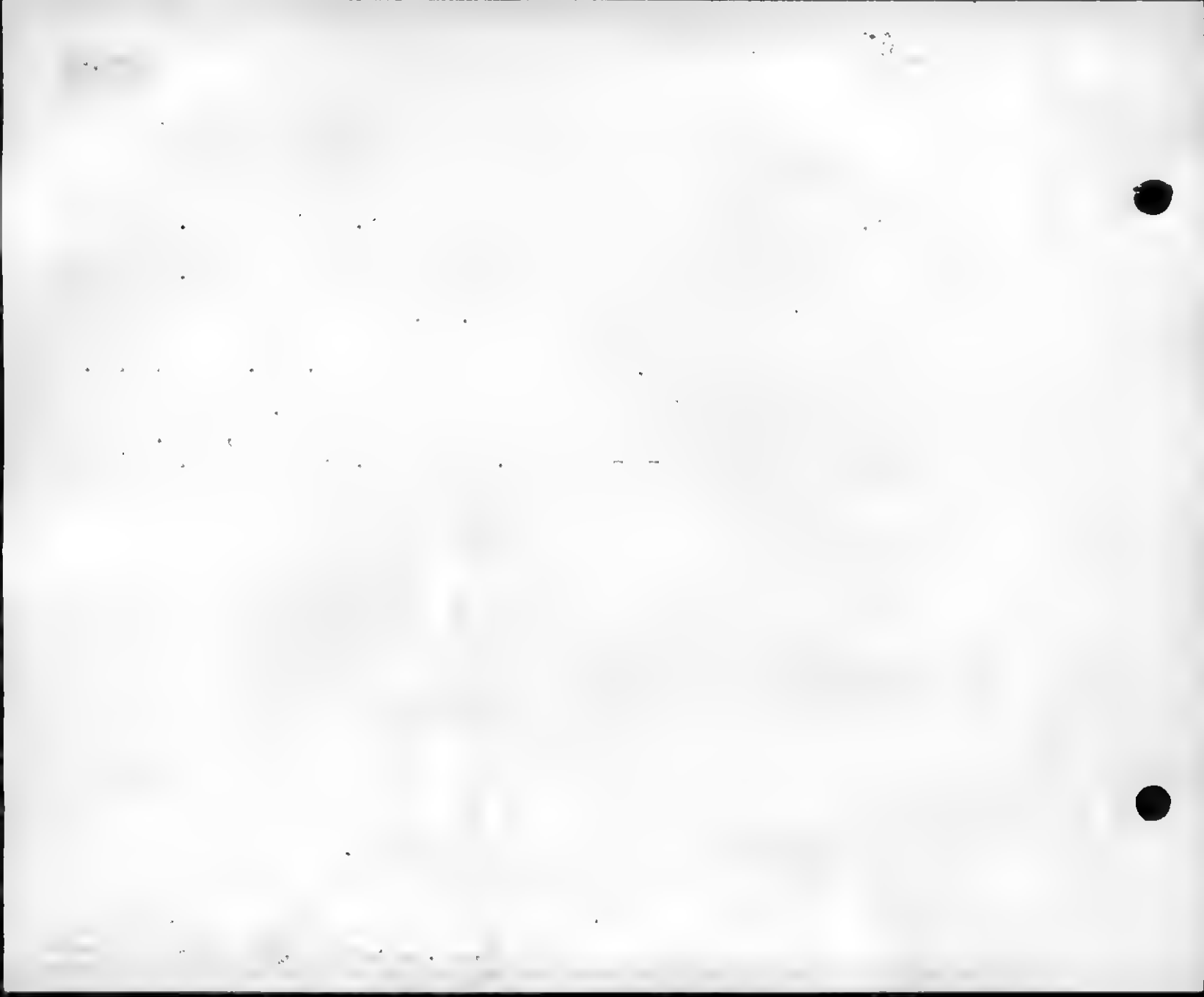
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04761

CERTIFICATE OF DEATH

04761

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>20 yrs</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>201 S. Symington Avenue</b>			d. STREET ADDRESS <b>201 S. Symington Ave.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ernest Owens Hepding</b>			4. DATE OF DEATH Month Day Year <b>Apr. 23, 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 20, 1905</b>		9. AGE (in years last birthday) <b>62 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P. Telephone Co. Baltimore Co., Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Augustus Hepding</b>			14. MOTHER'S MAIDEN NAME <b>Margaret E. Cornthwaite</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-05-0656</b>		17. INFORMANT <b>Catonsville, Md. 21228</b> <b>Mrs. Margaret A. Hepding 201 S. Symington Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crown Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Pericarditis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2/24, 1967</b> , to <b>4/23, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/14, 1967</b> , and that death occurred at <b>CA M</b> , from causes on the date stated above					
22a. SIGNATURE <b>Cliff Ratliff</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, MD</b>		22d. ADDRESS <b>4605 Edmonson Ave #25</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/26/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ellicott City, Maryland</b>	
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

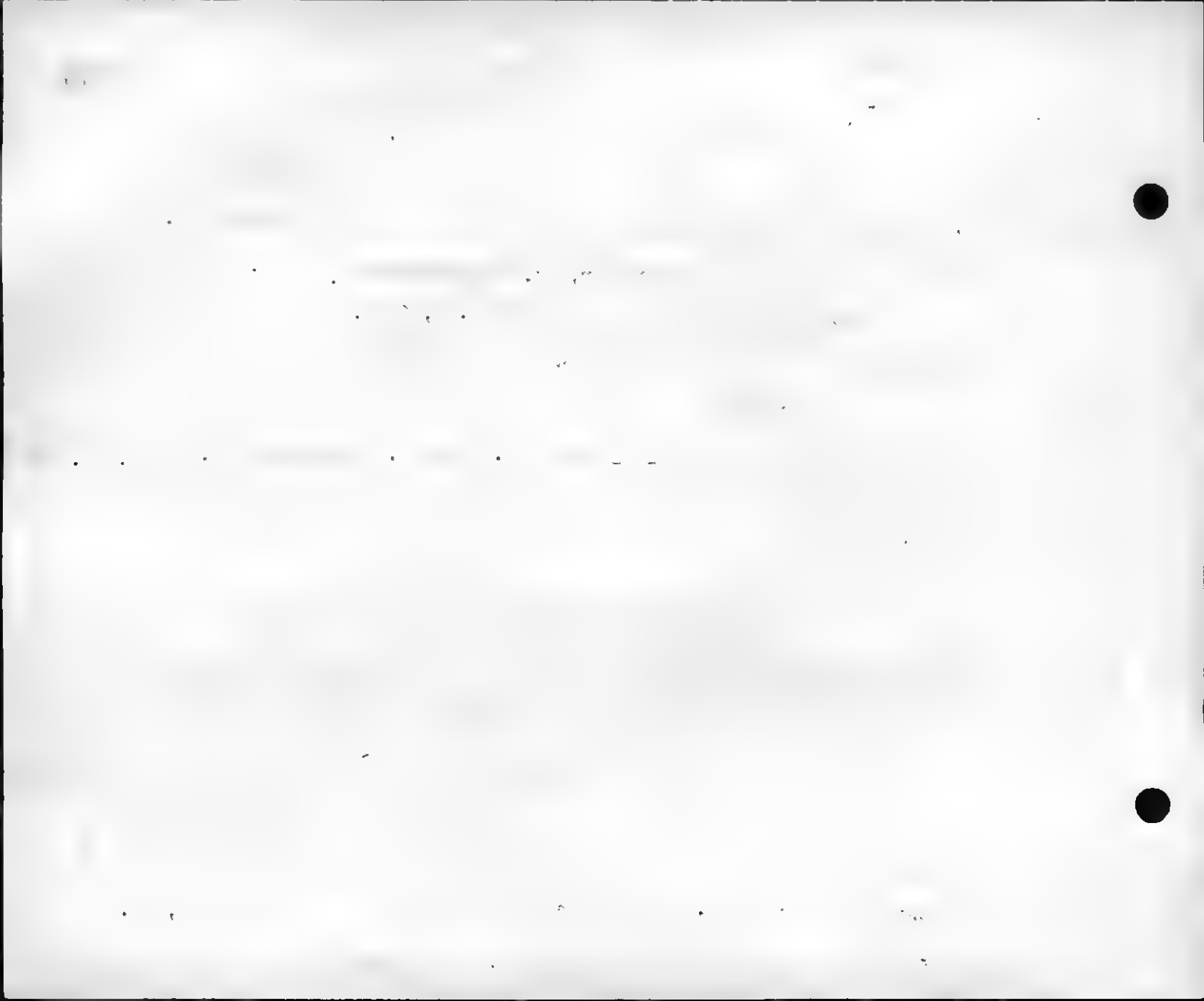
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04762

CERTIFICATE OF DEATH

04762

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>---</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c LENGTH OF STAY IN 1b	
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Nursing Home</u>		d STREET ADDRESS <u>2919 Hamilton Ave.</u>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hergenroeder, Sr.</u> Last <u>Hergenroeder</u>		4 DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 8, 1881.</u>
9. AGE (In years lost birthday) yrs <u>85</u>		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>215-32-2358A</u>	
17. INFORMANT <u>Mr. Henry R. Hergenroeder Sr. Balto. Md. #14</u>		Address <u>5336 Perring Pkwy</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>ASCVD with heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>20 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> , 19 <u>66</u> , to <u>4/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> PM, from causes and on the date stated above.			
22a SIGNATURE <u>James E. Rowe</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>4-21-67</u>
22c PHYSICIAN'S NAME (Type) <u>James E. Rowe</u>		22d. ADDRESS <u>5550 Baltimore National Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4/24/67.</u>	23c NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04763

CERTIFICATE OF DEATH

04763

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore, Towson</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c LENGTH OF STAY IN b <u>39 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>1907 South Carey</u>			
3 NAME OF DECEASED (Type or print) <u>Hignutt, Kenneth</u> First <u>Kenneth</u> Middle <u>—</u> Last <u>Hignutt</u>				4 DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1967</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>CAU.</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>11-28-09</u>	
9 AGE (In years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11 BIRTHPLACE (County & State or foreign country) <u>QUEEN ANNES Co. Md</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13 FATHER'S NAME <u>William Hignutt</u>			
14 MOTHER'S MAIDEN NAME <u>Duff NORA DULIN</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO <u>218-28-9567</u>				17 INFORMANT <u>WIFE</u> <u>Mrs. Henrietta Hignutt</u> Address <u>1007 S. Carey St. Baltimore, Maryland</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY OEDEMA</u> DUE TO (b) <u>CARDIAC FAILURE</u> DUE TO (c) <u>CARCINOMA OF LUNG WITH METASTASES</u>						INTERVAL BETWEEN ONSET OF DEATH <u>9 days</u> <u>9 days</u> <u>UNKNOWN</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>19</u> p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>67</u> , to <u>4/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>67</u> , and that death occurred at <u>6:30 P.M.</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Derek A Bruce</u>				22b DATE SIGNED <u>4/28/67</u>		22c PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>	
22d ADDRESS							
23a BURLIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
<u>BURIAL</u>		<u>MAY 1, 1967</u>		<u>CHESTERFIELD CEMETERY</u>		<u>CENTREVILLE, O.A. Co. Md.</u>	
24 FUNERAL DIRECTOR <u>James H. Barton, Jr. Barton Box, Centreville, Md.</u>				25a REC'D BY REGISTRAR DATE <u>MAY 2 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



22



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

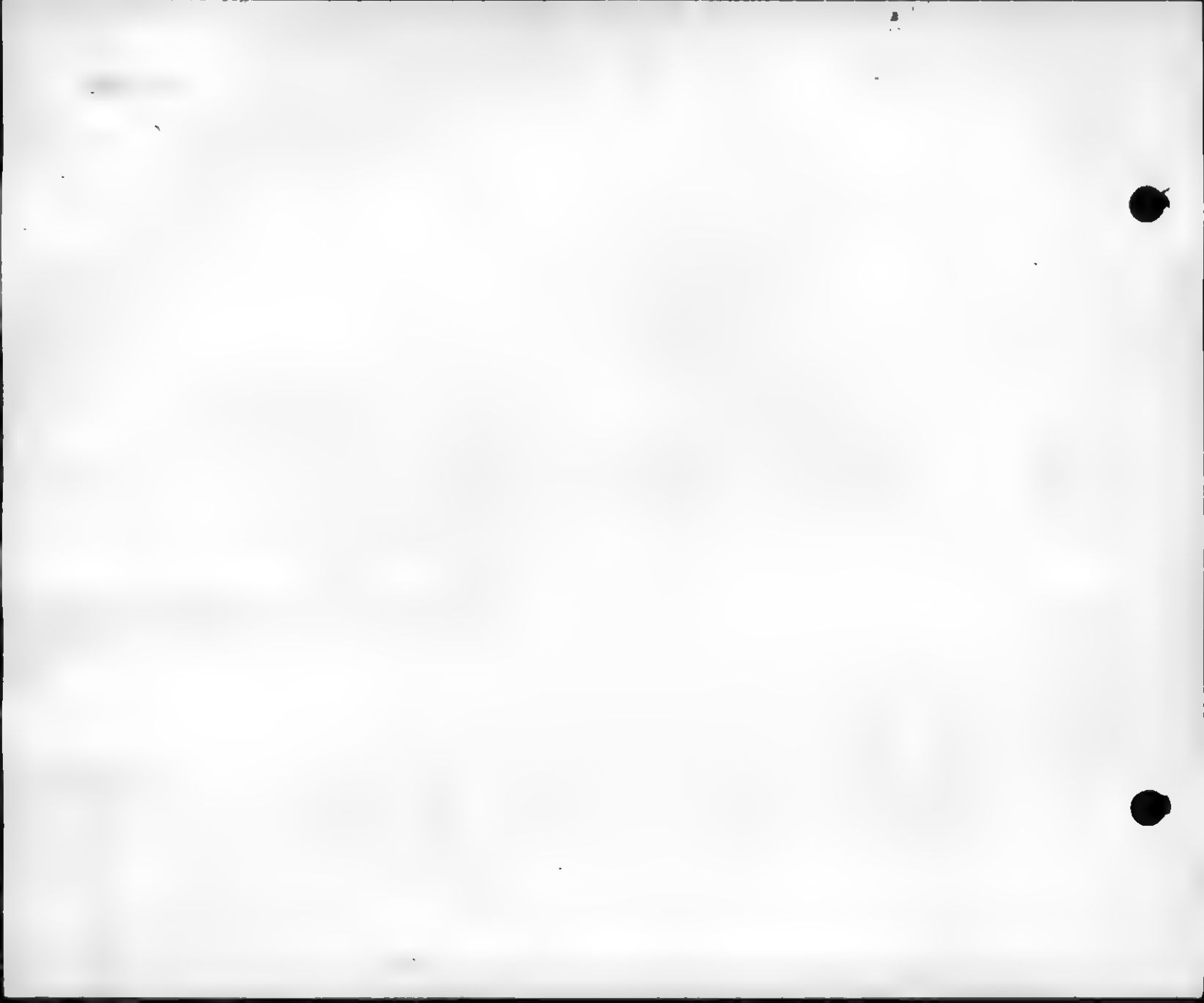
04764

04764

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, while RURAL, and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>STEWART LAWRENCE HILL</u>		4 DATE OF DEATH Month Day Year <u>APRIL 26, 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-19-1916</u>
9 AGE (In years lost birthday) <u>50</u> yrs		10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TECH. CLERK</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. GASKELEC.</u>		11 BIRTHPLACE (County & State or foreign country) <u>BALTIMORE, MD.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>215-09-9748</u>		17 INFORMANT <u>Patient's Chart</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE ANTERO-LATERAL MYOCARDIAL INFARCTION.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-24-</u> , 1967, to <u>4-26-</u> , 1967, that (I) (we) last saw the deceased alive on <u>4-26-</u> , 1967, and that death occurred at <u>6:35AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>E.K.S. Narayanan</u>		22b. DATE SIGNED <u>4-26-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.K.S. NARAYANAN, M.D.</u>		22d. ADDRESS <u>GREATER BALTO. MEDICAL CENTER, TOWSON, MARYLAND 21204.</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Buried</u>	23b. DATE THEREOF <u>Apr. 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fondren Park Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>John Burke Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

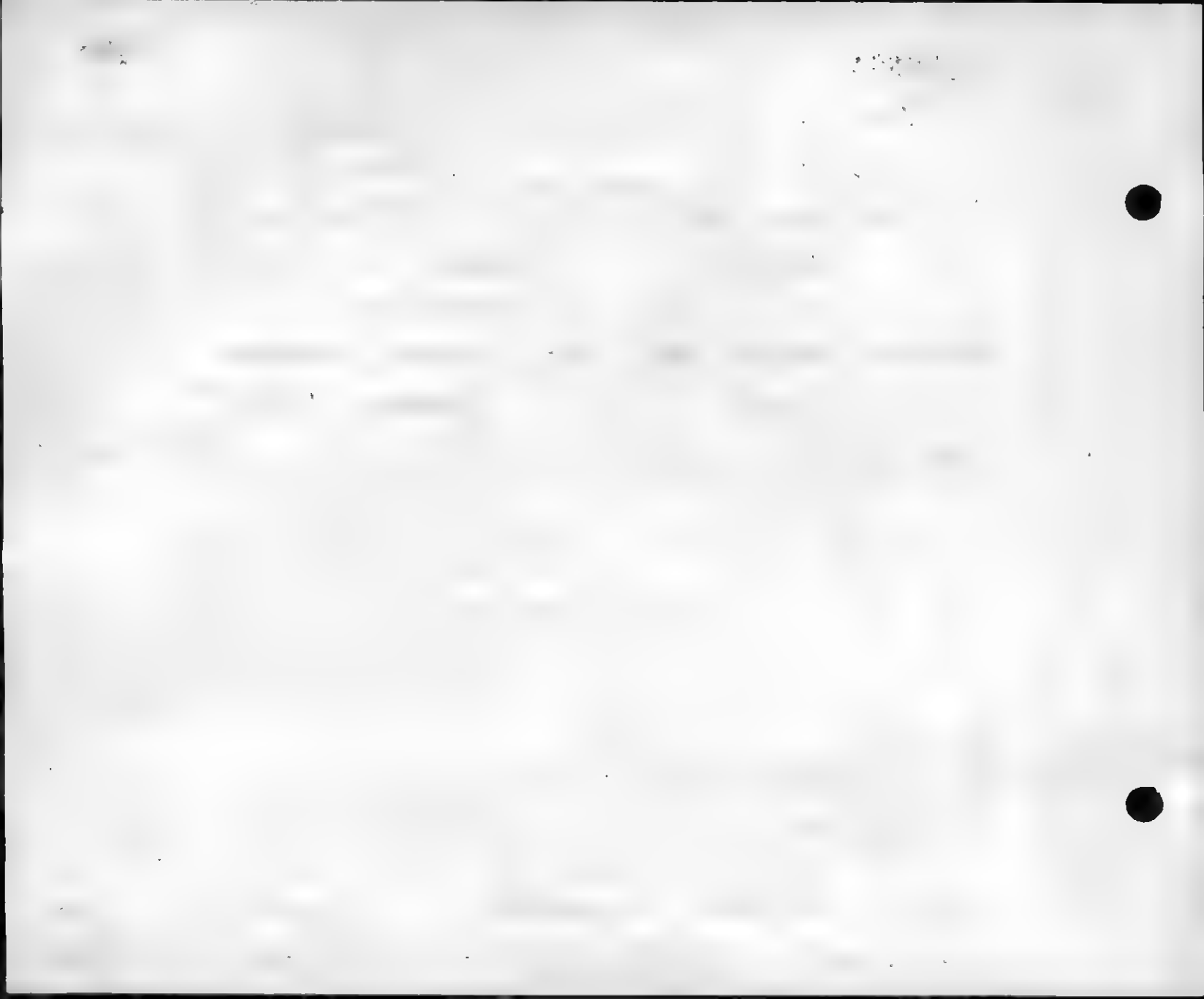
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04765  
CERTIFICATE OF DEATH  
04765

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 N. Beechwood Ave</u>				d. STREET ADDRESS <u>8 N. Beechwood Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Helen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1911</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COST ACCOUNTANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>				13. FATHER'S NAME <u>C. C. SWAIN</u>			
14. MOTHER'S MAIDEN NAME <u>FLORENCE PICKETT</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>W. Himes</u> Address <u>8 N Beechwood Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>Previous embolization to brain, kidneys, spleen</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous embolization to brain, kidneys, spleen</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1967</u> to <u>April 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1967</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>David W. Morse</u>				22b. DATE SIGNED <u>4/26/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David W. Morse M.D.</u>				22d. ADDRESS <u>University Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>4/26/67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>				23d. LOCATION (City, town or county) (State) <u>BALTO Md</u>			
24. FUNERAL DIRECTOR <u>C. S. MacNabb</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>APR 28 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04766

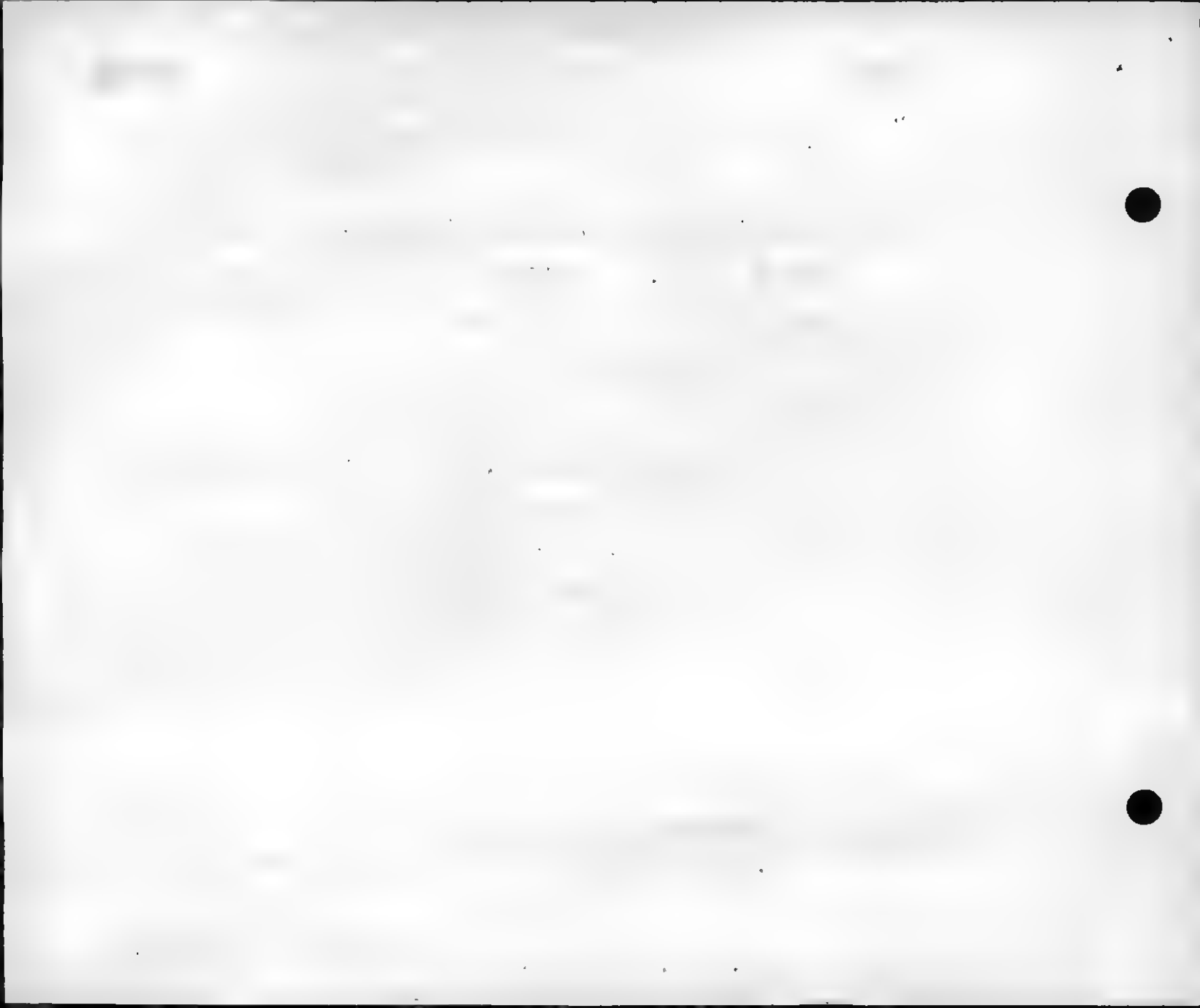
CERTIFICATE OF DEATH

04766

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>4720 PARK HEIGHTS AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>EDYTHE</b> Middle <b>J.</b> Last <b>HOFFMAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-25-04</b>
9 AGE (In years last birthday) <b>62</b> yrs		10 UNDER 1 YEAR Months Days Hours Min. 11 UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH ELOVER</b>		14. MOTHER'S MAIDEN NAME <b>LENA ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>218-12-6511</b>	
17. INFORMANT <b>MR. PHILIP HOFFMAN, 4720 PARK HEIGHTS AVE.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Carcinoma Liver</b> DUE TO (c) <b>Metastatic Carcinoma Lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>4/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/7</b> 19 <b>67</b> and that death occurred at <b>2:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. S. Hallinan</b>		22b. DATE SIGNED <b>4/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. EDWARD KALLINS</b>		22d. ADDRESS <b>LIBERTY HEIGHTS AVENUE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/9/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ADATH JESHURUN ADDRESS</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

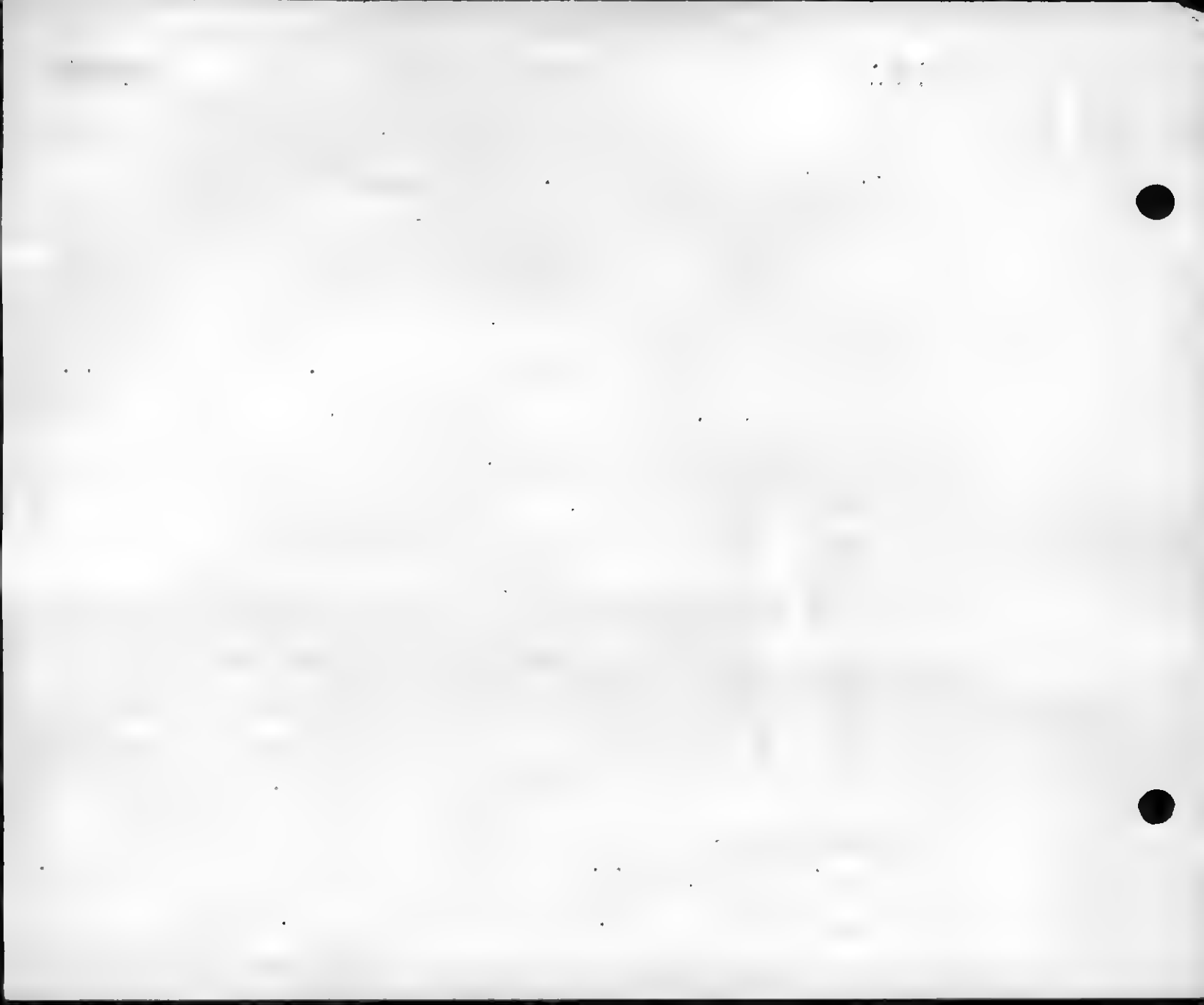
04767

## CERTIFICATE OF DEATH

04767

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>2105 Roxanne Court</b>	
3 NAME OF DECEASED (Type or print) First <b>Sylvia</b> Middle <b>Anne</b> Last <b>HOLT</b>		4 DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. CO. OR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-13-63</b>
9. AGE (In years lost birthday) <b>4</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Landon Burton Holt, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anne Young</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aspiration</b> <b>43X</b> DUE TO <b>Aspiration of Stomach Contents</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Acute Gastritis &amp; Gastroenteritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>6/21</b> , 19 <b>63</b> , to <b>4/23</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>4/23</b> , 19 <b>67</b> , and that death occurred at <b>7:15 A.M.</b> on <b>4/23</b> , 19 <b>67</b> , and on the date stated above.			
22a. SIGNATURE <b>Richard A. Jones</b>		22b. DATE SIGNED <b>24 Apr. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>		22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Alex. NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ALEX., VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



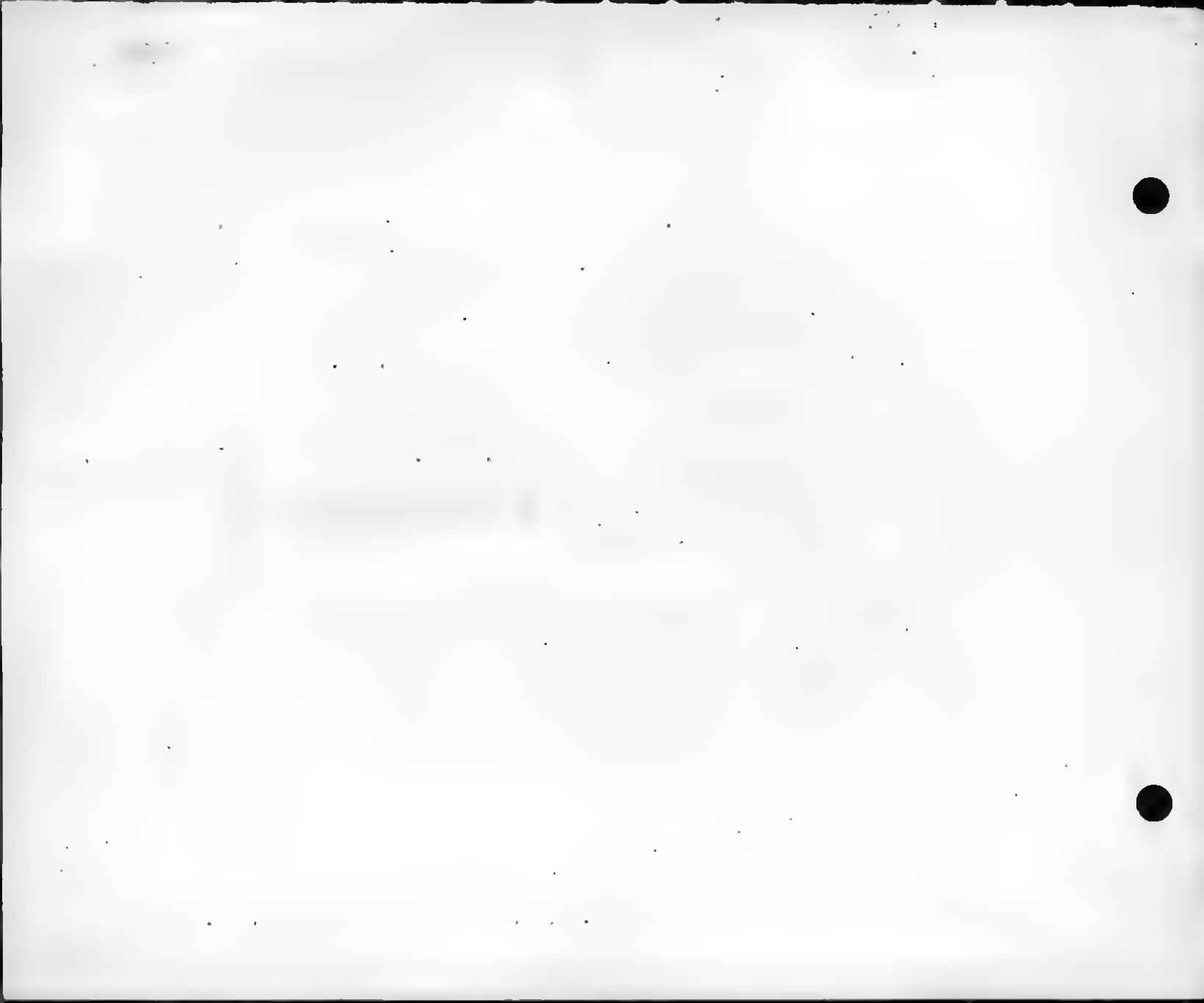


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7314 Philadelphia Rd.		d. STREET ADDRESS 7314 Philadelphia Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Russell C. Hood		4. DATE OF DEATH Month Day Year April 23, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1893	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Balto. Id.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unknown Hood		14. MOTHER'S MAIDEN NAME Leona Summers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes # 1		16. SOCIAL SECURITY NO. 705 07 1564		17. INFORMANT Mrs. Eliz. Hood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>HCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exogenous obesity</u>		19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Theo C Patterson</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/24/67	
EXAMINER'S NAME (Type) THEO. C PATTERSON		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4 26 1967		23c. NAME OF CEMETERY OR CREMATORY Balto. I. S. National	
23d. LOCATION (City, town or county) balto. d.		(State)			
24. FUNERAL DIRECTOR D. C. Gully		ADDRESS 130 E. Fort Ave		25a. REC'D BY REGISTRAR APR 26 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

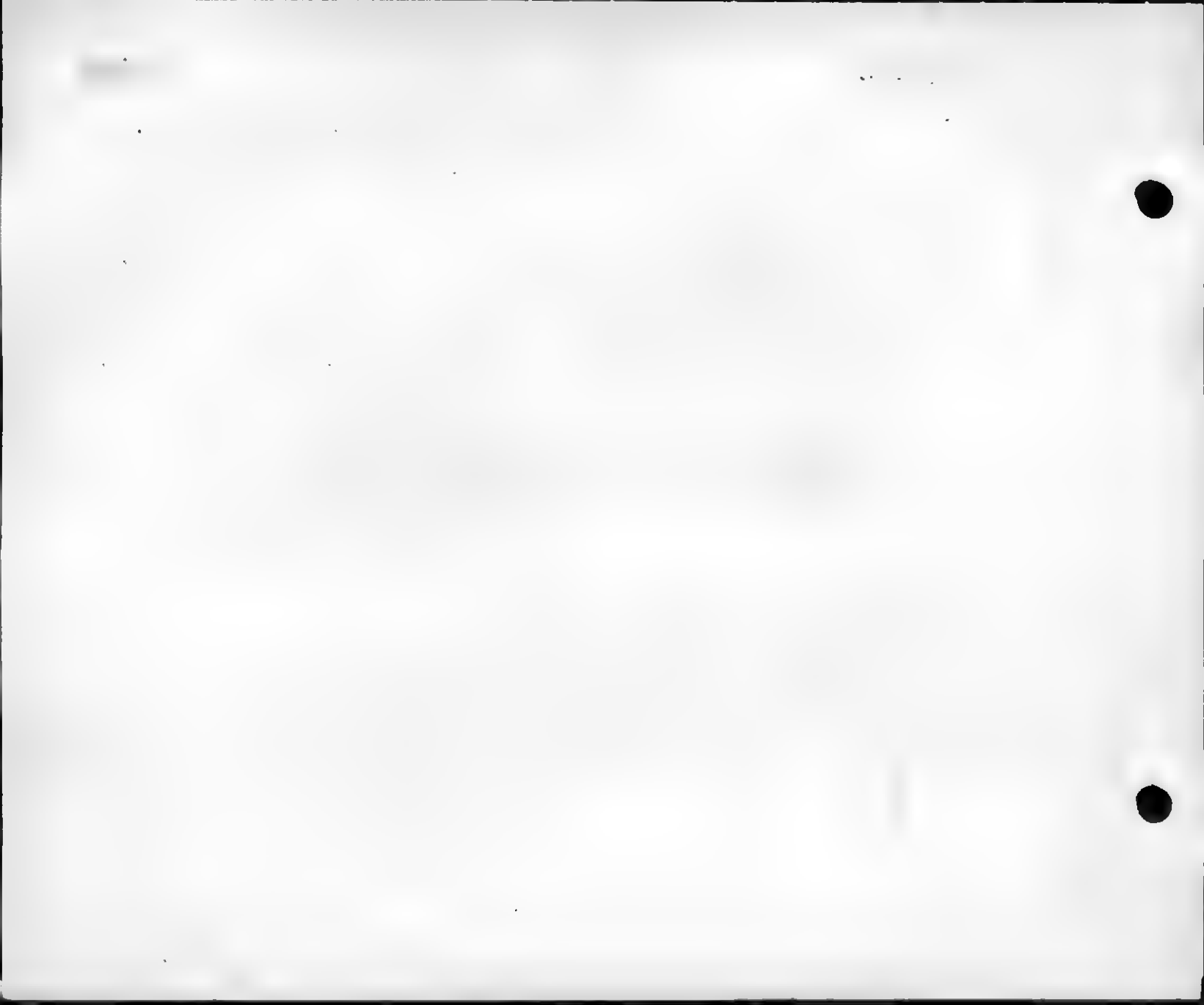
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04769

CERTIFICATE OF DEATH

04769

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La Nursing Home</b>		d. STREET ADDRESS <b>5713 Edmondson Ave A4</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Hopkins</b>		4. DATE OF DEATH <b>April 14, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 10, 1876</b>
9. AGE (in years last birthday) <b>90</b> YES		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas Howes</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Schekells</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MARY EDNA HOPKINS - Same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Age</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1967</b> to <b>April 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1967</b> , and that death occurred at <b>5:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Lee J. Volenick</b>		22b. DATE SIGNED <b>4/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee J. Volenick MD</b>		22d. ADDRESS <b>4710 Liberty Hts Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-17-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR <b>ELLSWORTH ARMACOST-4610 Liberty Hts</b>		25a. REC'D BY REGISTRAR <b>Charles J. ...</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>		DATE <b>APR 19 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04770

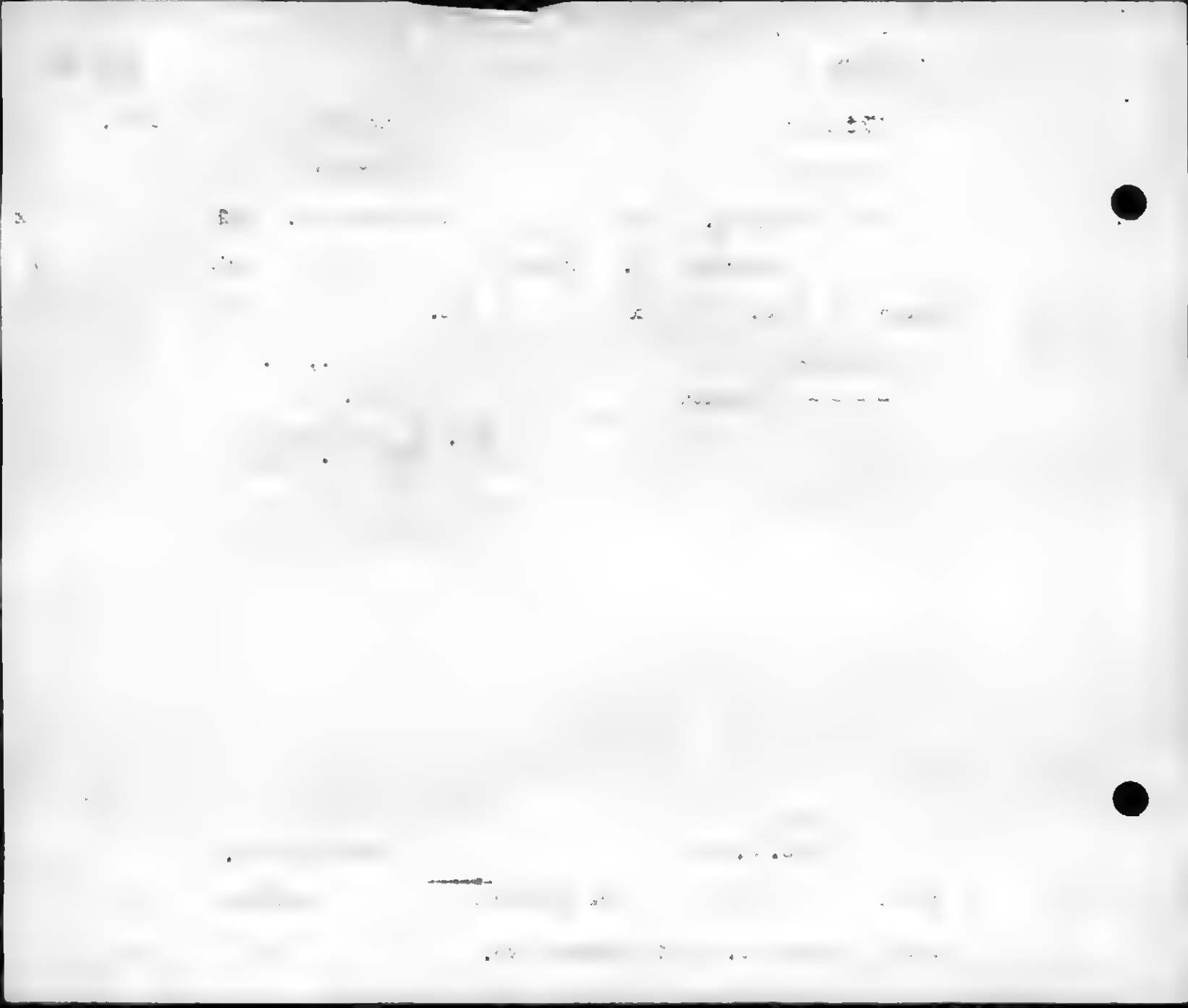
CERTIFICATE OF DEATH

04770

1. PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Balte.</b>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>504 Academy Rd. 21228</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>E.</b> Last <b>Horton</b>		4 DATE OF DEATH Month <b>April</b> Day <b>22</b> , Year <b>67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 12/87</b>
9 AGE (In years lost birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min <b>79</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arnreich</b>		14. MOTHER'S MAIDEN NAME <b>Unk.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Philip McKenna</b> <b>504 Academy Rd. - 21228</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> (c) <b>March 1967</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Year</b>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 1967, to <b>4/22</b> , 1967, that (I) <del>saw</del> saw the deceased alive on <b>4/21</b> 1967, and that death occurred at <b>3:4</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Jas. J. Nolan</b>		22b. DATE SIGNED <b>4/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jas. J. Nolan</b>		22d. ADDRESS <b>1 Mallow Hill Rd.</b>	
23a BURIAL CREMATION, etc. (Specify) <b>Burial</b>	23b DATE THEREOF <b>4/25/1967</b>	23c NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>
24 FUNERAL DIRECTOR <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		25a REC'D BY REGISTRAR DATE <b>APR 25 1967</b>	
25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

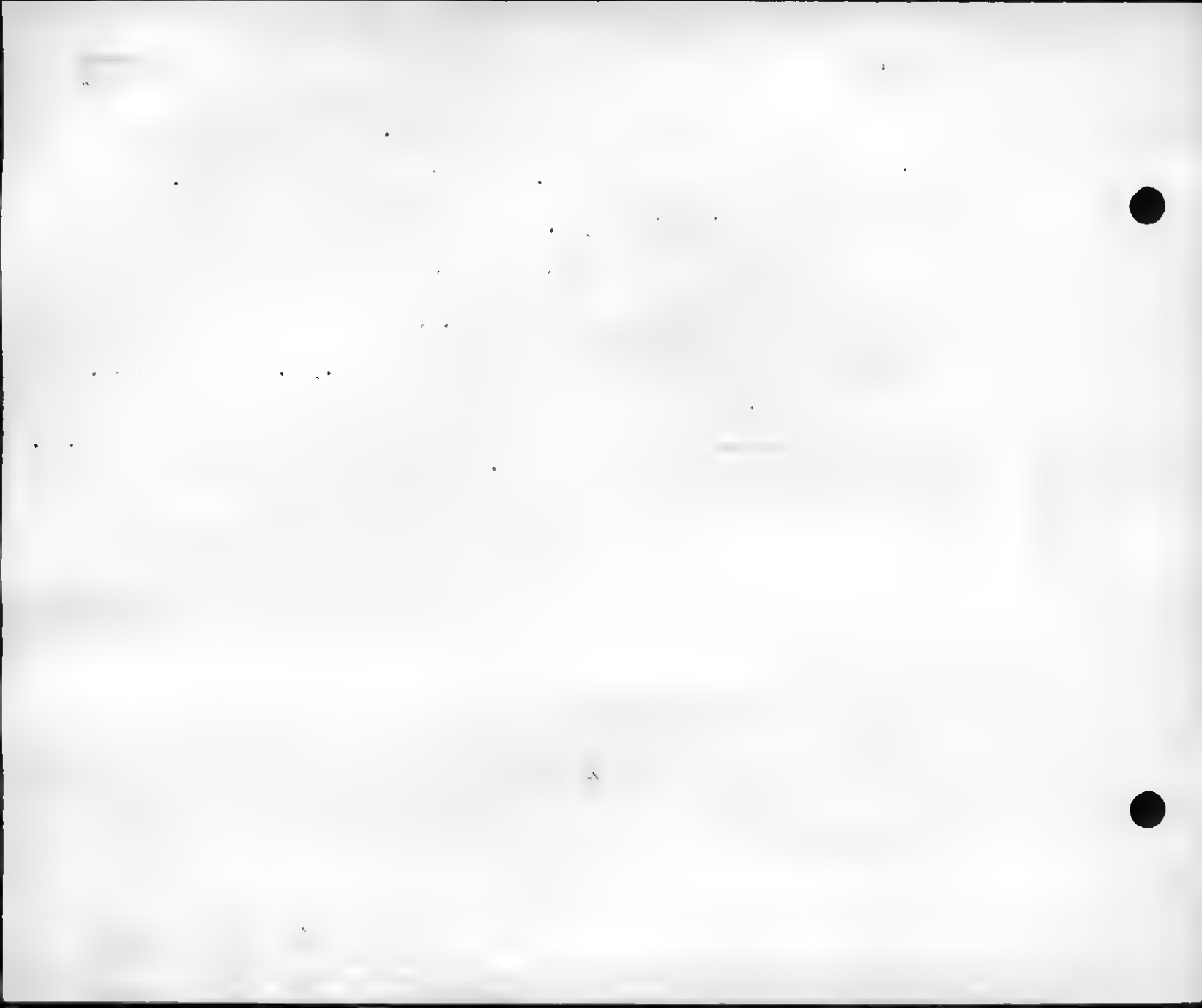
04771

CERTIFICATE OF DEATH

04771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only events within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>22 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 Linden Terrace, Pikesville 8, MD.</u>		e. STREET ADDRESS <u>10 Linden Terrace</u>	
3 NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Elizabeth</u> Last <u>Houck</u>		4 DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 7, 1885</u>
9 AGE (In years lost birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Carroll Co., MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Louis Green</u>		14. MOTHER'S MAIDEN NAME <u>Stella Cookman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>Mr. Charles Elmer Houck, 10 Linden Terrace, Pikesville 8, MD.</u>		Address <u>Pikesville 8, MD.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO (b) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>of virus infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u> <u>2 weeks</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture Ribs</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> 19 <u>67</u> to <u>4-9-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-8-</u> 19 <u>67</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell</u>		22b. DATE SIGNED <u>4-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>		22d. ADDRESS <u>Reisterstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Maryland</u>
24 FUNERAL DIRECTOR <u>Frank H. Howell</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
ADDRESS <u>Pikesville 8, MD</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04772

## CERTIFICATE OF DEATH

04772

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c LENGTH OF STAY in 1b <u>3 weeks</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>		d STREET ADDRESS <u>Nelson Road</u>	
3 NAME OF DECEASED (Type or print) <u>EDWARD EVERETT HUGHES</u>		4 DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-26-95</u>
9 AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Edward E. Hughes</u>		14 MOTHER'S MAIDEN NAME <u>Janie Chaffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>216-019025</u>	
17 INFORMANT <u>Hosp.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Degenerative Collapse</u>			
DUE TO <u>  </u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u>			
DUE TO <u>  </u>			
(c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-27-1965</u> to <u>4/17/67</u> , that (I) (we) last saw the deceased alive on <u>4/17/67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above			
22a SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. G. G. G.</u>		22d. ADDRESS <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 21, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>  </u>		23d. LOCATION (City or town) (County) (State) <u>  </u>	
24. FUNERAL DIRECTOR <u>Frank J. Newell, Inc.</u>		25a. REF. D. BY REGISTRAR <u>  </u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>APR 25 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04773

04773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21218</u> d. STREET ADDRESS <u>645 McKewin</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Annie</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>21</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>11-16-1875</u>		<b>9. AGE</b> (in years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York city, N.Y.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Joseph W. Mattingly</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lettie Ann Jarboe</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>218-52-1108</u>		<b>17. INFORMANT</b> <u>Hospice records</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Draining chest wall Sinus</u> DUE TO (c) <u>ASCVD</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4-14-56</u> <b>to</b> <u>4-21-</u> <b>19</b> <u>1967</u> <b>, that (I) (we) last saw the deceased alive on</b> <u>4-21-67</u> <b>and that death occurred at</b> <u>1.04 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>[Signature]</u>		<b>22b. DATE SIGNED</b> <u>4-21-67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. J. Mahon, MD</u>			
<b>22d. ADDRESS</b> <u>204 E. Joppa Rd.</u>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-24-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Balto. Md.</u>		<b>(State)</b> _____					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook-Brooks Towson, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 25 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

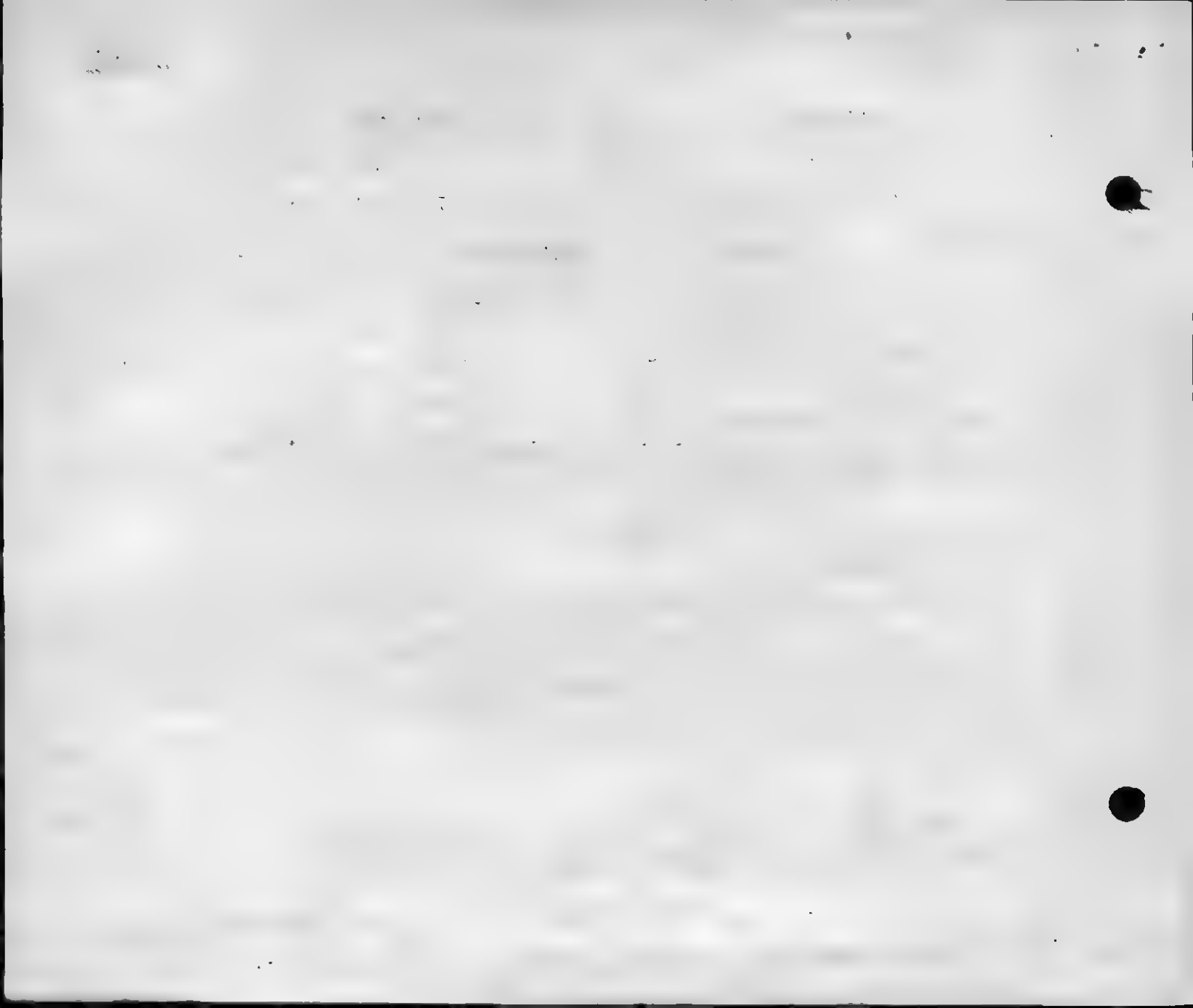
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04774

04774

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>65 yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>7101 Fait Avenue</b>		d. STREET ADDRESS <b>7101 Fait Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frances Janiszewski</b>		First <b>Frances</b>		Middle <b>Janiszewski</b>		Last <b>Janiszewski</b>		4. DATE OF DEATH <b>4-25</b>		Month <b>4</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-24-1886</b>		9. AGE (in years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>25</b> IF UNDER 24 HRS Hours <b>0</b> Mn. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-09-7015B</b>		17. INFORMANT <b>Frances Sauer 7101 Fait Avenue</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Vascular Accident</b> <b>H/O</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>H/O</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>7101 Fait Avenue</b> DATE SIGNED <b>4/24/67</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-29-67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>					
23. FUNERAL DIRECTOR <b>Walter Dabrowski 1005 Dundalk Avenue</b>		24a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

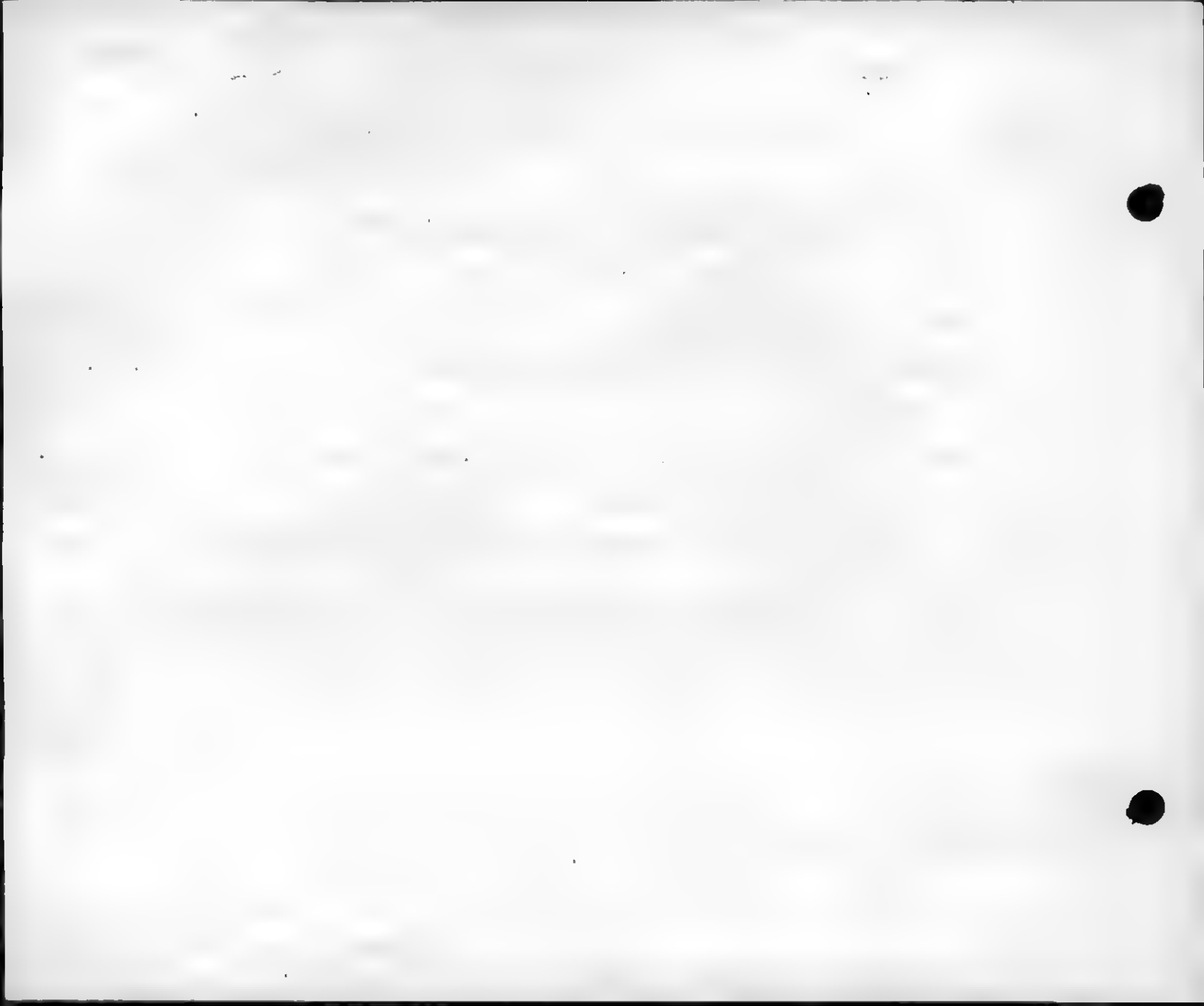
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04775

CERTIFICATE OF DEATH

04775

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>2614 FOSTER AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>JOSEPH</b> Last <b>JASKOWICK</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/9/1897</b> AGE (In years last birthday) <b>72</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEARMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL COMPANY</b>	11. BIRTHPLACE (County & State, or foreign country) <b>RUSSIA</b>
13. FATHER'S NAME <b>PETER JASKOWICK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>216 10 50 41</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>CARCINOMA OF FLOOR OF MOUTH WITH METASTASES</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>  <b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/5/67</b> , 19 to <b>4/25/67</b> , 19, that (I) (we) last saw the deceased alive on <b>4/25/67</b> , 19, and that death occurred at <b>2:10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>4/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>KACZEROWSKI FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 1 1967</b>	25b. REGISTRAR'S SIGNATURE <i>J. Charles, Judge</i>



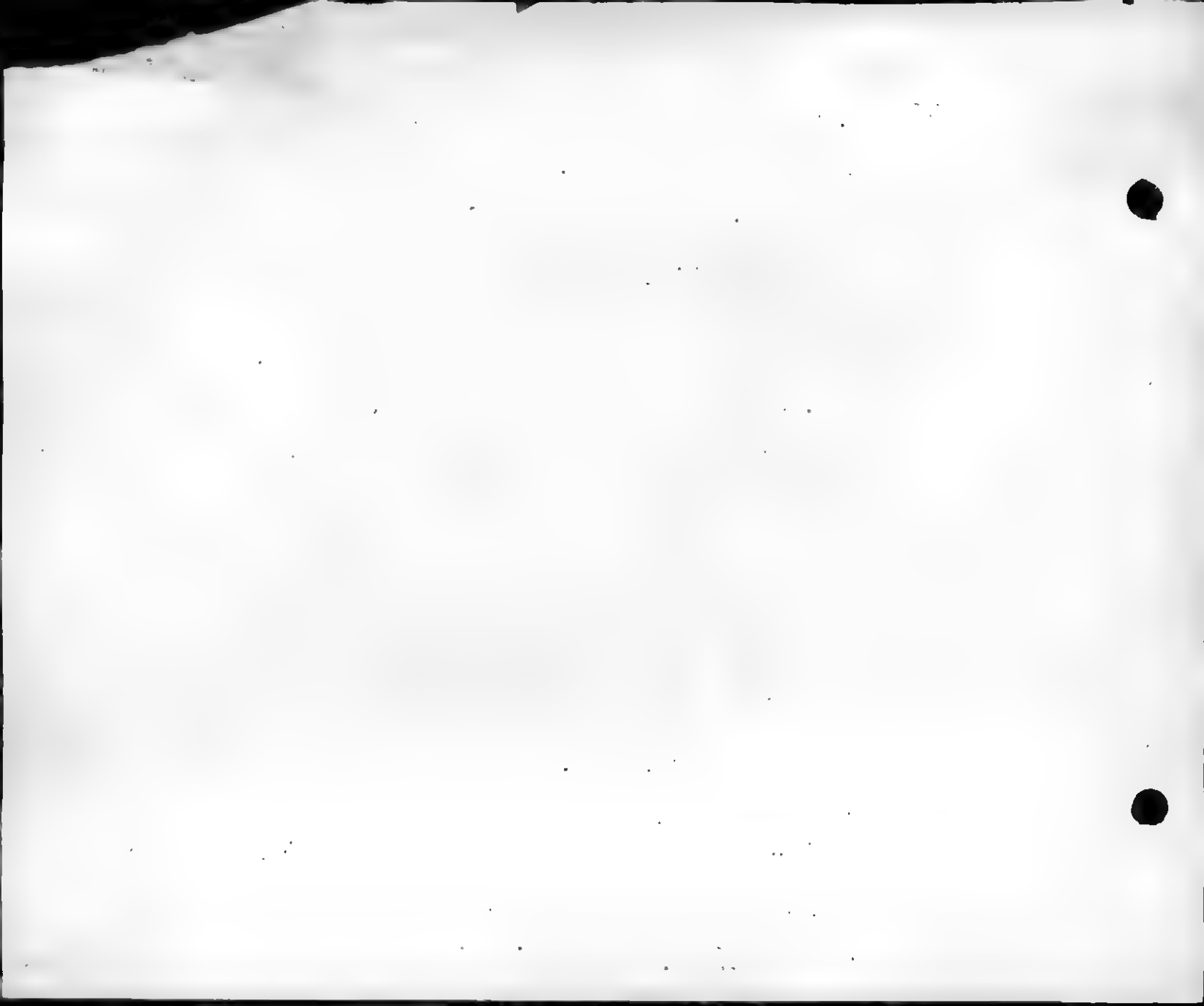


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The **1** requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE  
04776  
CERTIFICATE OF DEATH 04776

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>6 1/2 yrs.</u>		d. STREET ADDRESS <u>325 Stratford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>325 Stratford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>H.</u> Last <u>JENKINS</u>		4. DATE OF DEATH <u>April 19, 1967</u> 19 <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1898</u> 68 yrs.
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Brokers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward F. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Agnes M. Hamilton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>213-09-6878</u>	
17. INFORMANT <u>Mrs Marquerite C. Jenkins</u>		Address <u>325 Stratford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE &amp; ARTERIO</u> DUE TO <u>SCHEMATIC CARDIOVASCULAR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>67</u> , to <u>4/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thos E Roach</u>		22b. DATE SIGNED <u>4/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thos E Roach</u>		22d. ADDRESS <u>5550 Bartonville Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemt</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>STERLING FUNERAL ESTATE</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
ADDRESS <u>736 Edm. Av. Catonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04777

04777

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6904 Mornington Road</b>				d STREET ADDRESS <b>6904 Mornington Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>CHESTER</b> Last <b>JOLLETT</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5th</b> Year <b>19 67</b>			
5 SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>June 11, 1883</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13 FATHER'S NAME <b>Burton L. Jollett</b>				14 MOTHER'S MAIDEN NAME <b>Louise Sullivan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO. <b>213-07-1709A</b>		17. INFORMANT Address <b>Mrs. Cora M. Jollett, same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>myocardial ischemia</b> DUE TO (c) <b>arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4/5</b> , 19 <b>67</b> , to <b>4/5</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>4/5</b> , 19 <b>67</b> , and that death occurred at <b>9:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7001 Mornington Road Dundalk, Maryland 21222</b> DATE SIGNED <b>4/6/67</b>							
ACTUAL SIGNATURE <b>Eugene F. Nevy</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy, M.D.</b>							
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b DATE THEREOF <b>4/8/67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		22d LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 21222</b>				24a REC'D BY REGISTRAR <b>APR 10 1967</b>		24b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

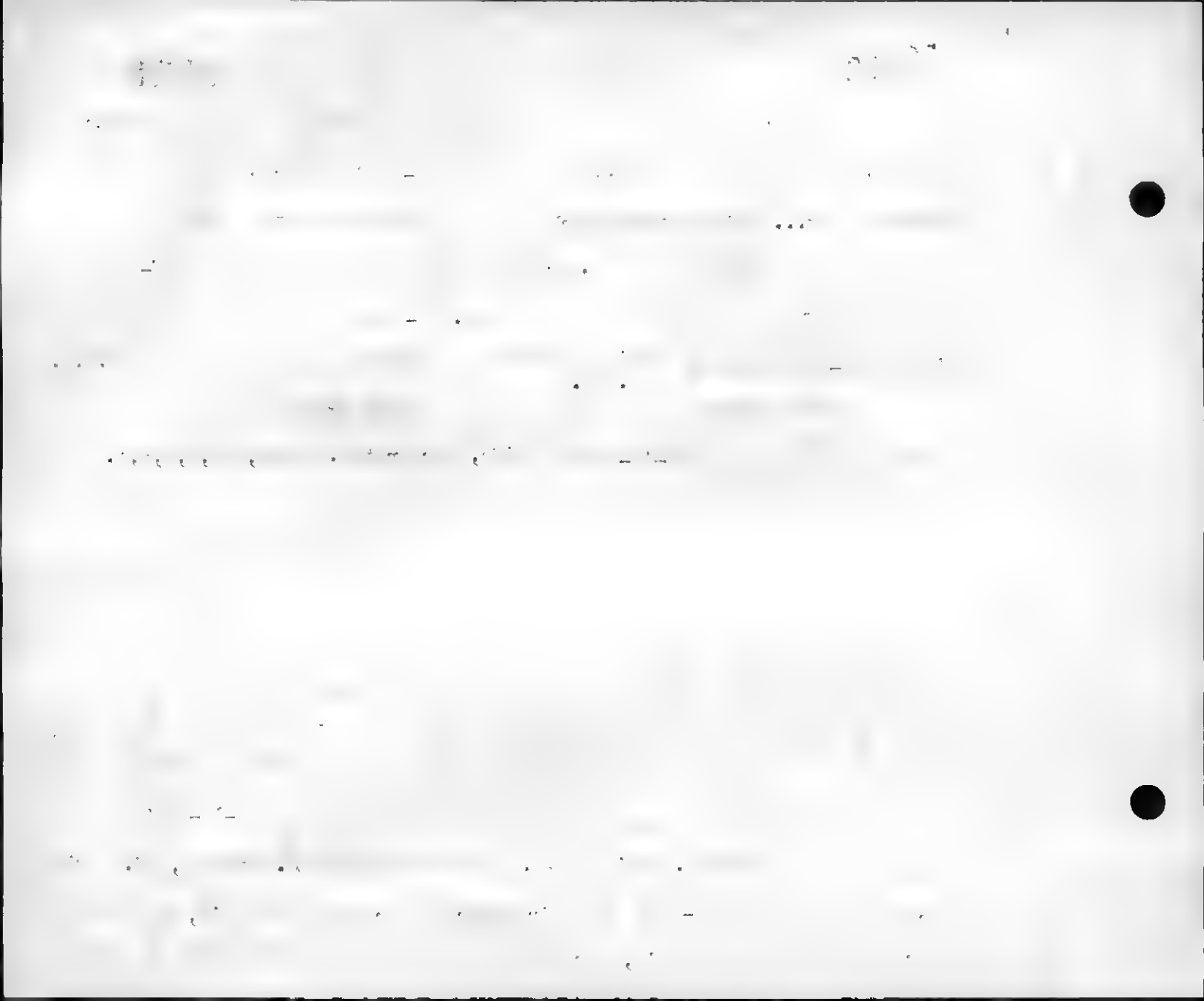
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04778

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Edgemere - 19</b>				c LENGTH OF STAY IN b <b>Hours</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Bay... Old Bay Shore Park</b>				d STREET ADDRESS <b>18 A Westway South 21220</b>			
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>LEONARD</b> Last <b>Jones</b>				4 DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 26- 1943</b>	9 AGE (In years last birthday) <b>23</b> yrs	F UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min <b>23</b>	F UNDER 24 HRS Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min <b>23</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance-Construction</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Office Trailer Mfg. Co.</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13 FATHER'S NAME <b>Ralph Jones</b>				14 MOTHER'S MAIDEN NAME <b>Helen Ragan</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16 SOCIAL SECURITY NO <b>219-40-5116</b>		17 INFORMANT <b>Wife, Margaret A. Jones, #2,a,b,c,d.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> <b>50X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Boat Swamped + Threw MAN IN WATER</b>			
20c TIME OF INJURY Month Day Year <b>1701 4-17 1967</b>				20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY Home farm (State) (City or town, County) (State) <b>Edgemere-Baltimore Md-</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> 4-17-1967			
EXAMINER'S NAME (Type) <b>Melvin B. Davis M.D. 6800 Mornington Rd. Dundalk, Md. 21222</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>April 19-1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d LOCATION (City or town) (County) (State) <b>Bel Air, Maryland</b>	
24 FUNERAL DIRECTOR <b>Foster Funeral Home, Bel Air, Maryland 21014</b>				25a REC'D BY REGISTRAR <b>APR 19 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ <sup>forward</sup> page carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

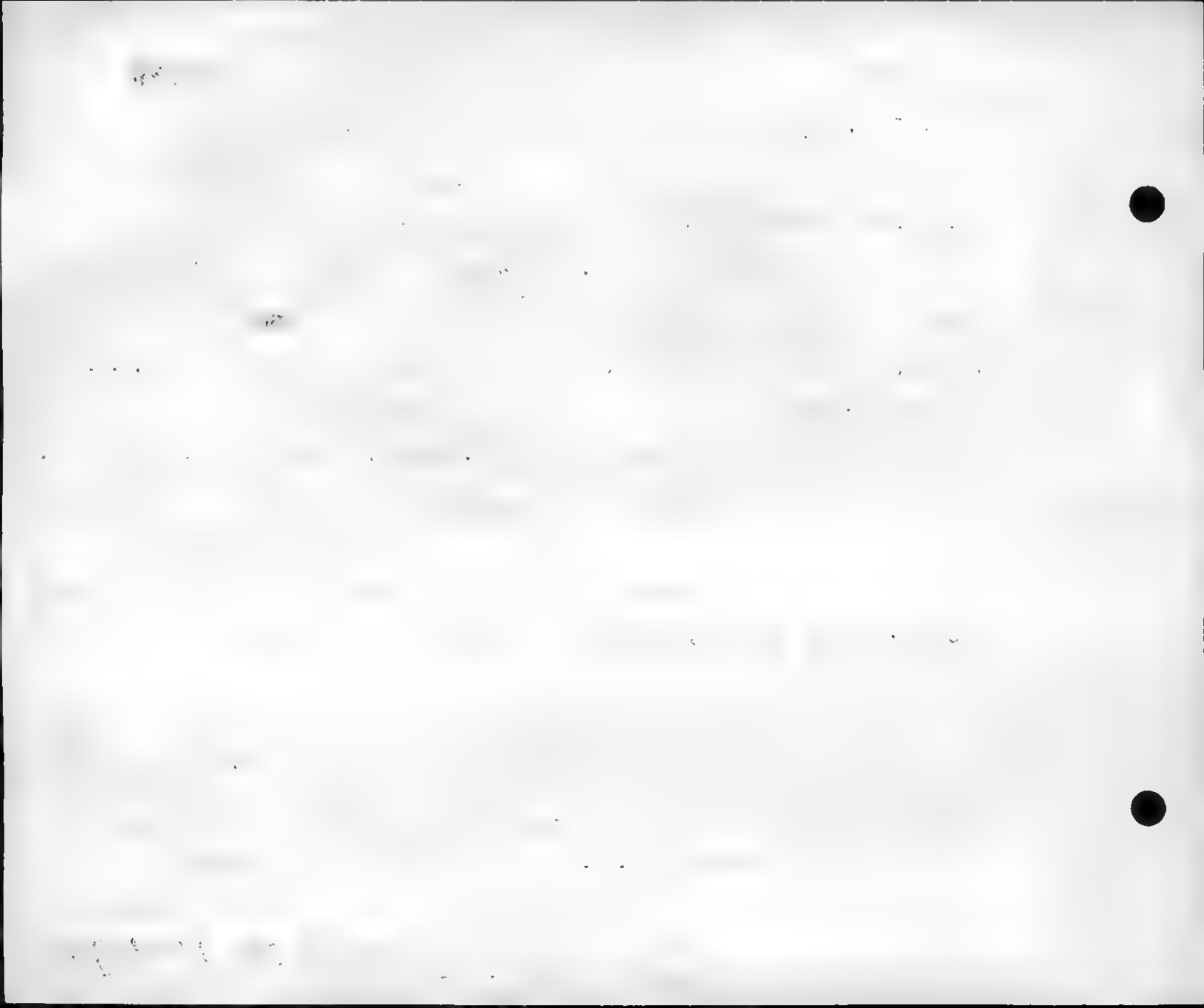
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04779

04779

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>18 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. STREET ADDRESS <b>794 GRANTLEY AVENUE</b>			
3 NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>C.</b> Last <b>JONES</b>				4 DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/10</b>	9. AGE (In years last birthday) <b>57</b> yrs	10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PITTSYLVANIA, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>HENRY JONES</b>			
14. MOTHER'S MAIDEN NAME <b>POKIE CRAFT</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WW II</b>			
16. SOCIAL SECURITY NO <b>218 07 66 23</b>				17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC INSUFFICIENCY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PYELONEPHRITIS, KLEBSIELLA AEROBACTER; STATUS SUBTOTAL GASTRECTOMY FOR DUODENAL ULCER</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>4/7/67</b> , 19 <b>67</b> , to <b>4/25/67</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>4/25/67</b> , 19 <b>67</b> , and that death occurred at <b>1:25 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Neilson Neilson</i> MD				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILSON NEILSON, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETT FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04780

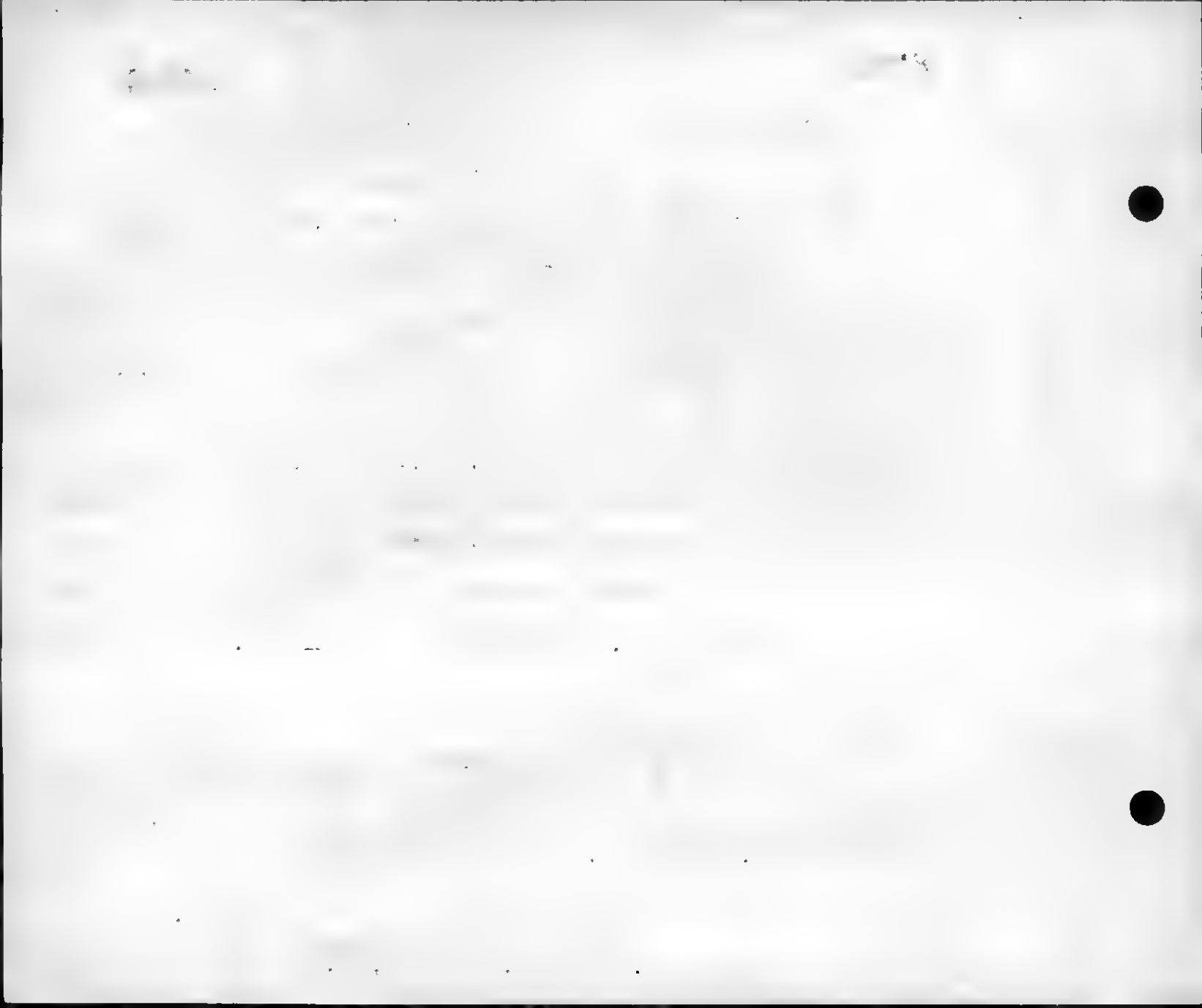
**CERTIFICATE OF DEATH**

04780

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>25 DAYS</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>645 BARTLETT AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ALBERT</b> Last <b>JONES</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>24</b> Year <b>19 67</b>		5 SEX <b>MALE</b>		6 COLOR OR RACE <b>NEGRO</b>	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>11 21 12</b>		9 AGE (In years last birthday) <b>54</b> Yrs		10 IF UNDER 1 YEAR Months <b>5</b> Days <b>11</b> Hours <b>21</b> Min <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>STOCK MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING MFG.</b>		11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOHN JONES</b>				14 MOTHER'S MAIDEN NAME <b>EDITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>		16 SOCIAL SECURITY NO <b>218 01 85 72</b>		17 INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SPONTANEOUS PNEUMOTHORAX LEFT, MASSIVE</b> DUE TO (b) <b>PULMONARY EMPHYSEMA, MARKED</b> DUE TO (c) <b>BRONCHOGENIC CARCINOMA RIGHT UPPER LOBE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN PROSTATIC HYPERTROPHY</b> <b>PULMONARY CONGESTION &amp; EDEMA. ARTERIOSCLEROTIC HEART DISEASE.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <b>3/30/67</b> , 19 <b>67</b> , to <b>4/24/67</b> , 19 <b>67</b> , that <del>we</del> (we) last saw the deceased alive on <b>4/24/67</b> , 19 <b>67</b> , and that death occurred at <b>5:15AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				22b. DATE SIGNED <b>4/24/67</b>		22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>	
23a. BURIAL, CREMATION, REMOVA, (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/24/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>	
24. FUNERAL DIRECTOR <i>Marshall P. Hayes</i>		25. REG. BY REGISTRAR <b>MARSHALL P. HAYES FUNERAL</b>		26. REG. BY REGISTRAR <b>N. GILMOR ST. BALTIMORE</b>		27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04781

04781

1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>				c. LENGTH OF STAY IN 1b <u>WOODLAWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>DOGWOOD RD. RT. 5</u>				d. STREET ADDRESS <u>DOGWOOD RD. RT. 5</u>			
3 NAME OF DECEASED (Type or print) <u>BERTHA C. KAHLER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1967</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV. 10, 1885</u>	9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK STIRN</u>				14. MOTHER'S MAIDEN NAME <u>EVA STIRN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>218-36-1897D</u>		17. INFORMANT <u>Mr. G. EDWIN KAHLER</u> Address <u>DOGWOOD RD RT. 5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multifocal Myeloma, &amp; Bone Metastasis</u> <u>SOBK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21 I certify that (I) (the hospital) attended the deceased from <u>APRIL 1950</u> to <u>APRIL 26</u> , 1967, that (I) (we) last saw the deceased alive on <u>4/24/67</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Thomas E. Wheeler</u>				22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER MD</u>	
				22d. ADDRESS <u>RANDALLSTOWN - MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		23d. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN T. STANSBURY, SR.</u>				ADDRESS <u>4411 WINDSOR MILL RD.</u>		25a. REC'D BY REGISTRAR <u>APR 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Thomas E. Wheeler</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

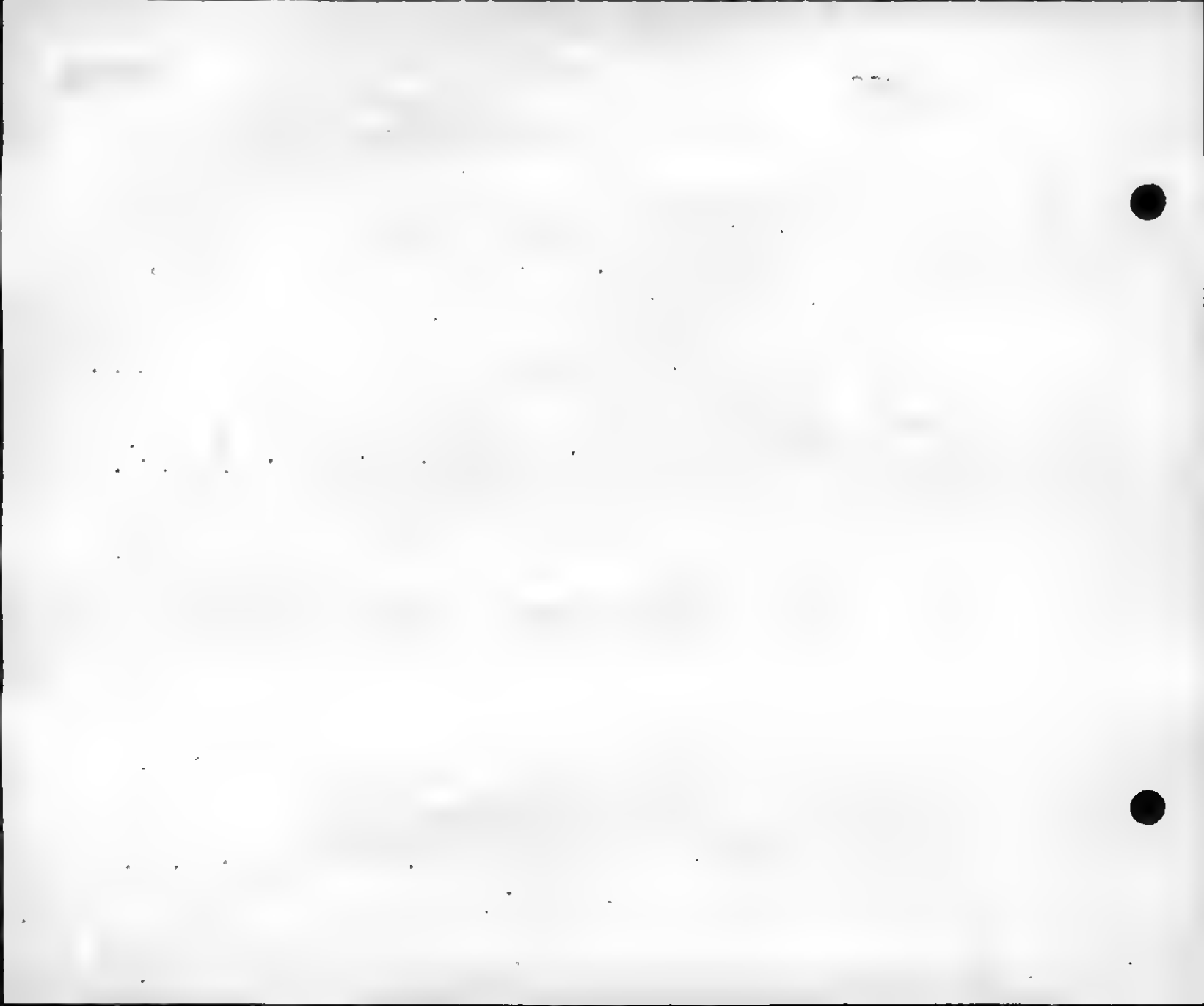
04782

04782

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural, Baltimore</b>		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3343 Washington Avenue</b>		d STREET ADDRESS <b>3343 Washington Avenue</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>E.</b> Last <b>Kandefer</b>		4 DATE OF DEATH Month <b>April</b> Day <b>22</b> , Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1908</b>
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. JS JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comptometer operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cloverland Dairy</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Taylor, Penna</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Reichwalder</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Mitnick</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>219-10-9493</b>	
17 INFORMANT <b>Edward W. Kandefer Sr.</b>		Address <b>3343 Washington Ave Balto 7. Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cervical carcinoma stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>16 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 31, 1966</b> to <b>Sept 22, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 21, 1967</b> , and that death occurred at <b>3:00 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Harry Kelmenson</b>		22b. DATE SIGNED <b>Sept 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry Kelmenson</b>		22d. ADDRESS <b>2 E. Read Street Balto. Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St John's Catholic Church</b>	23d. LOCATION (City or town) (County) (State) <b>Taylor Penna.</b>
24 FUNERAL DIRECTOR <b>Foring Byers</b>		25a. REC'D BY REGISTRAR <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 AM 1/66

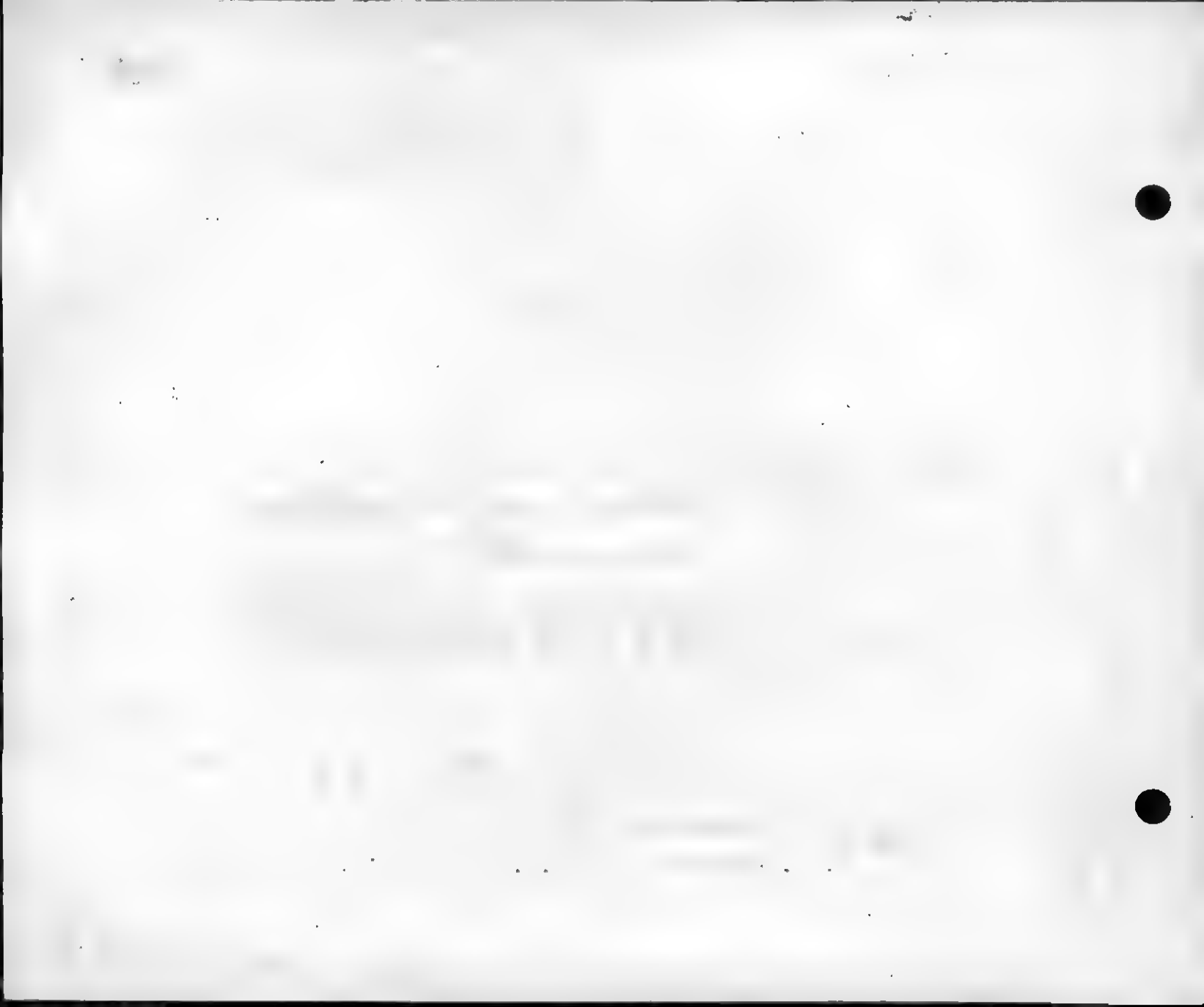
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04783

CERTIFICATE OF DEATH

04783

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>799 SILVER AVE</u>				d. STREET ADDRESS <u>799 SILVER AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PATRICK J.</u> Middle <u>KEARNS</u> Last <u>KEARNS</u>				4. DATE OF DEATH Month <u>APR</u> - Day <u>25TH</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-4-1907</u>	9. AGE (in years last birthday) <u>59</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN KEARNS</u>				14. MOTHER'S MAIDEN NAME <u>MARY CURRAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ELLA KEARNS (WIFE)</u> Address <u>SAME AS ABOVE</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peripheral vascular collapse</u> DUE TO <u>carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>carcinoma of rectosigmoid</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 mo</u> <u>8 mo</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia, complete small bowel obstruction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>25 April</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>21 April</u> 19 <u>67</u> , and that death occurred at <u>8 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>S. J. DeMarco III</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. J. DeMarco, III, M.D.</u>				22d. ADDRESS <u>715 N. Charles ST.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO - CO. - MD</u>	
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u> ADDRESS <u>300 MACE AVE</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

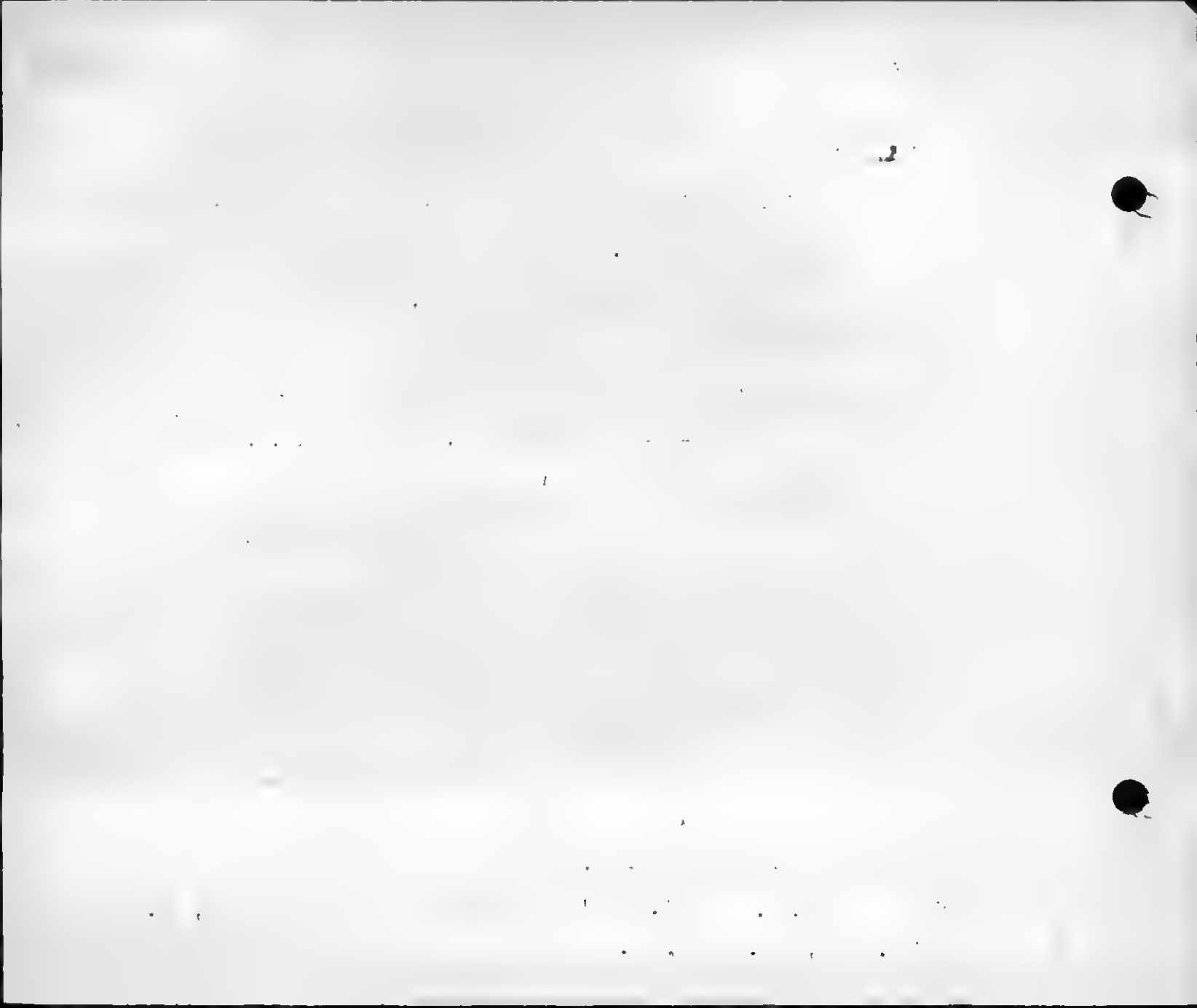
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04784

04784

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>Mercy Villa Nursing Home</b>				d. STREET ADDRESS <b>25 W. Pennsylvania Ave. Towson</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 9, 1890</b>		9. AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Joseph Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Lynch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-3737</b>		17. INFORMANT <b>Sister M. Carlotta, R.S.M., Mercy Villa</b> Address <b>6400 Bellona Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Cardio-Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>8-10 yrs</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-2</b> , 19 <b>67</b> , to <b>4-23</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>4-23</b> , 19 <b>67</b> , and that death occurred at <b>7:00 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip D. Flynn</b>				ADDRESS (Street, city or town, state) <b>11 E. Chase St. Baltimore Md.</b> DATE SIGNED <b>4/24/67</b>			
PHYSICIAN'S NAME (Type) <b>Philip D. Flynn, M. D.</b>							
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26.67.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Long Green, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				24a. REC'D BY REGISTRAR <b>APR 27 1967</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

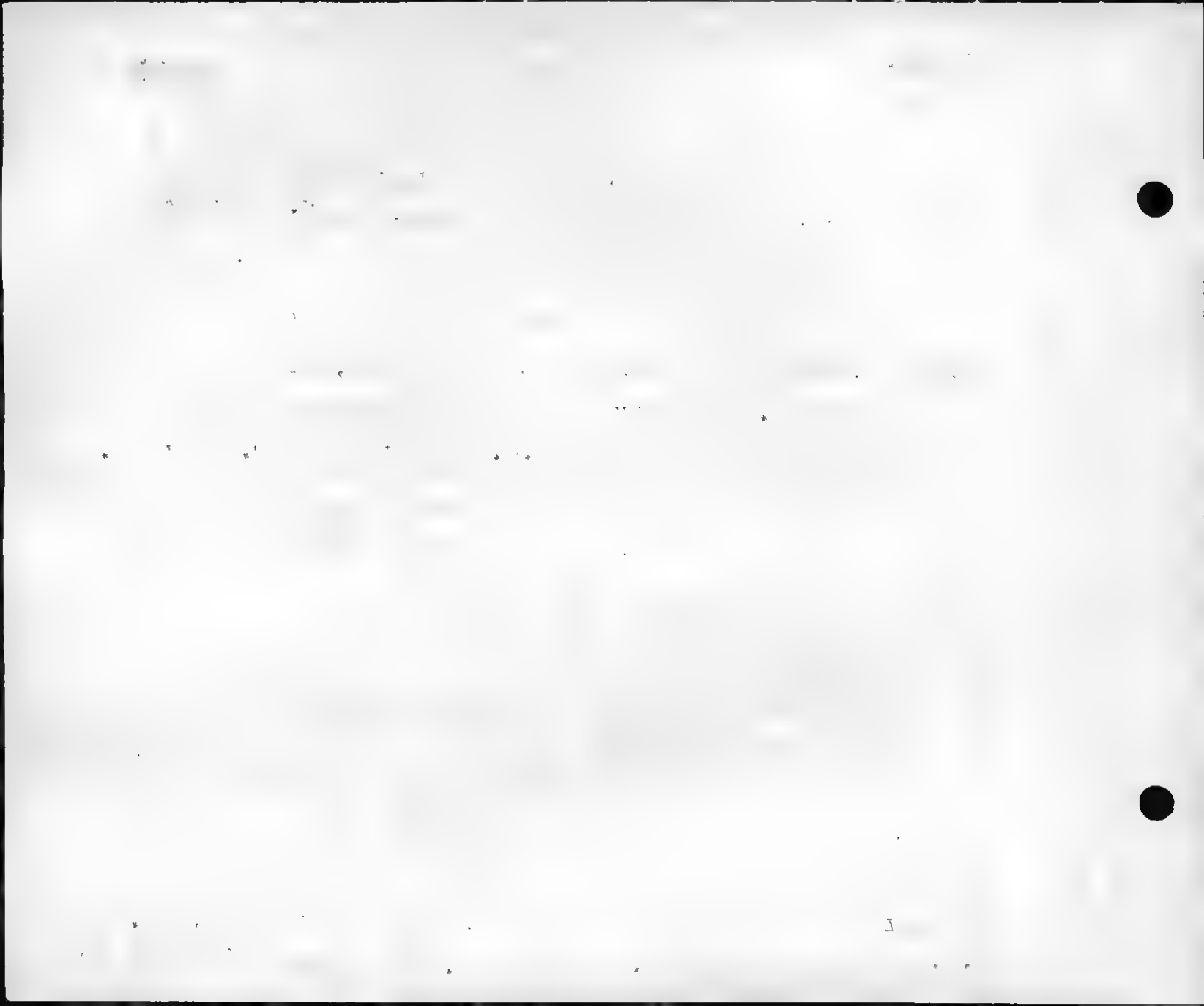
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04785

CERTIFICATE OF DEATH

04785

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>2 WKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
3. NAME OF DECEASED (Type or print) <u>HOLMES</u> <u>H.</u> <u>KENNERLY</u>		d. STREET ADDRESS <u>707 ST. PAUL ST</u> <u>XXXXXXXXXXXXXXX</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CHAUFFEUR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RIVERTON, MD.</u>	
13. FATHER'S NAME <u>ANDREW J. KENNERLY</u>		14. MOTHER'S MAIDEN NAME <u>MARY MARGARET BENNETT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>B.J. KENNERLY</u>		Address <u>707 ST. PAUL ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO (b) <u>bronchogenic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>1 yr?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>67</u> to <u>4/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>67</u> , and that death occurred at <u>8A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Maurice Feldman Jr</u> M.D.		22b. DATE SIGNED <u>4/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAURICE FELDMAN JR</u>		22d. ADDRESS <u>2 E READ ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>RIVERTON CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>RIVERTON, MD.</u>	
24. FUNERAL DIRECTOR <u>H.W. MEARS &amp; SON</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04786

04786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1928 BRUNT STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>LEE</b> Last <b>KESTON, JR.</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/96</b>
9. AGE (in years last birthday) yrs <b>71</b>		10. FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL LEE KESTON, SR.</b>		14. MOTHER'S MAIDEN NAME <b>JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>218 05 59 39</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>4/13/67</b> , 19 to <b>4/21/67</b> , 19, that (we) last saw the deceased alive on <b>4/21/67</b> , 19, and that death occurred at <b>11:05 AM</b> from causes and on the date stated above			
22a. SIGNATURE <b>CONRADO L. MANCAO, M.D.</b>		22b. DATE SIGNED <b>4/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CONRADO L. MANCAO, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-26-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Charles Law Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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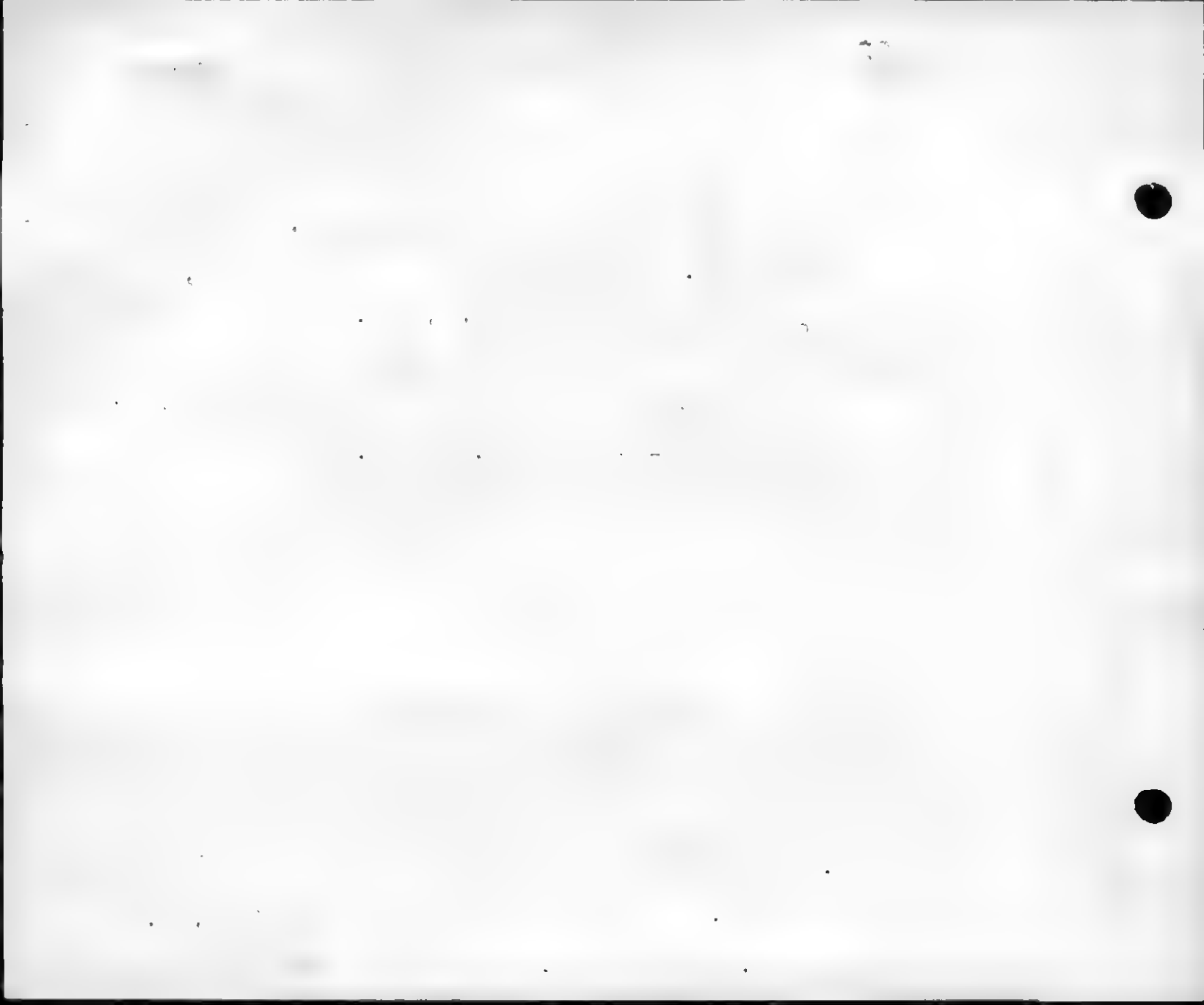
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04787

CERTIFICATE OF DEATH

04787

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>Perry Hall Medical Center</b>				d. STREET ADDRESS <b>6008 Eunice Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen I. Kijowski</b>				4. DATE OF DEATH <b>April 5, 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 1, 1898.</b>	
9. AGE (In years last birthday) <b>68</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland / Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank Shanofski</b>		14. MOTHER'S MAIDEN NAME <b>Kondra Kijowski</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. co.) <b>no</b>	
16. SOCIAL SECURITY NO <b>214-22-1104</b>		17. INFORMANT <b>Mrs. Edward M. Gregory</b>		Address <b>(Same)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1967</b> , to <b>Apr. 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 2, 1967</b> , and that death occurred at <b>7:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Donald Jandorf</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Donald Jandorf</b>				22d. ADDRESS <b>6077 Harford Road</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>APR 7 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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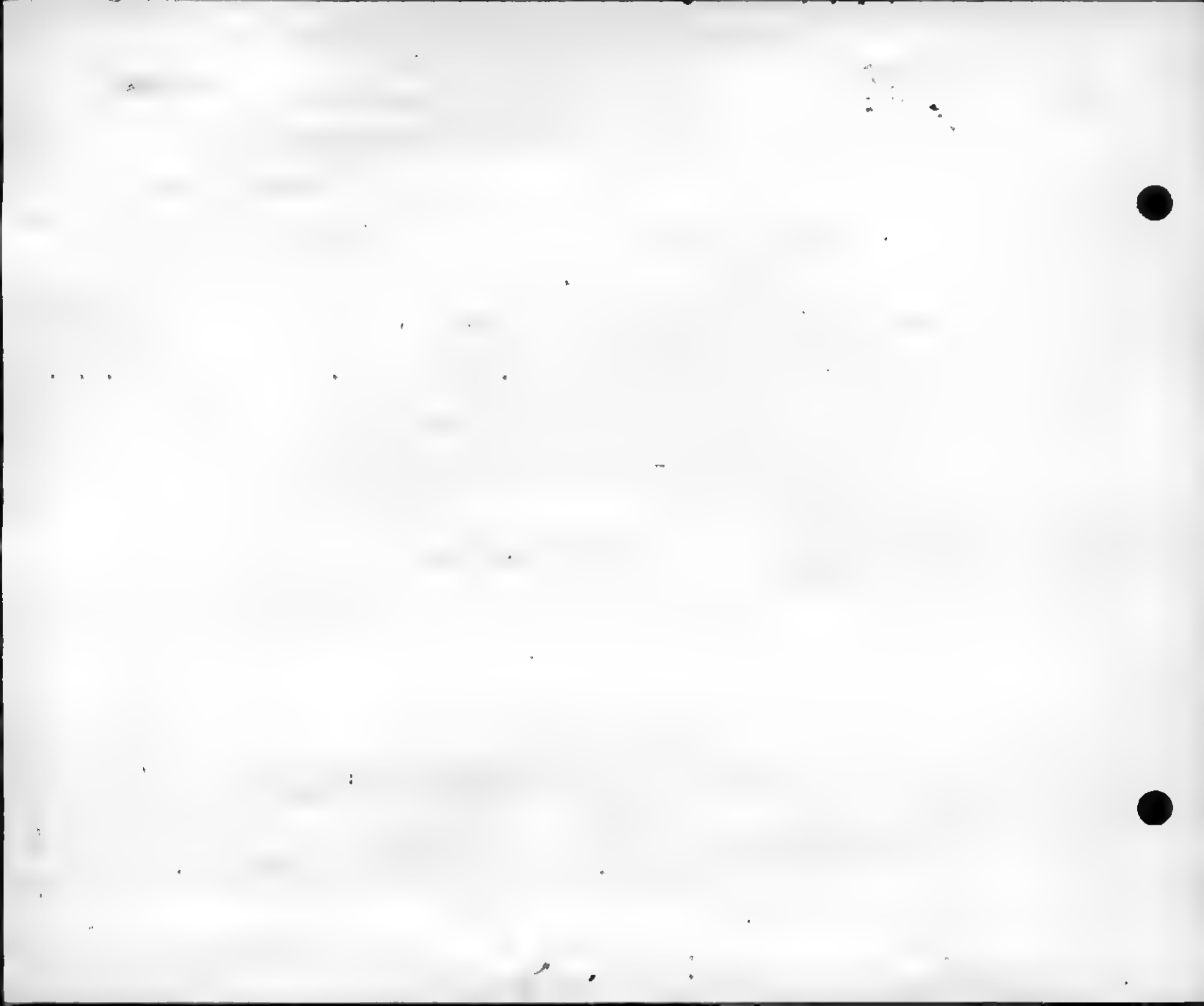
04788

MARYLAND STATE DEPARTMENT OF HEALTH  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 Items #13 & 14 Filed 4/26/67

CERTIFICATE OF DEATH

04788

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>				d. STREET ADDRESS <b>6220 Mossway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Winona G. KING</b>				4. DATE OF DEATH Month Day Year <b>April 21 19 67</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1888</b>	9. AGE (In years last birthday) <b>78</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education-Balto. City Minn.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eugene Greiman</b>				14. MOTHER'S MAIDEN NAME <b>Carrie/ Virginia Boyer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>820-00-5426</b>		17. INFORMANT <b>Alton B. King</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>578X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Diffuse intestinal bleeding.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atherosclerosis, generalized, marked.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 8</b> , 1967, to <b>April 21</b> , 1967, that (I) (we) last saw the deceased alive on <b>April 21</b> , 1967, and that death occurred at <b>5:45</b> M. from causes and on the date stated above							
22a. SIGNATURE <b>Juane S. Cockburn</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Juane S. Cockburn, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>York Pa/</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

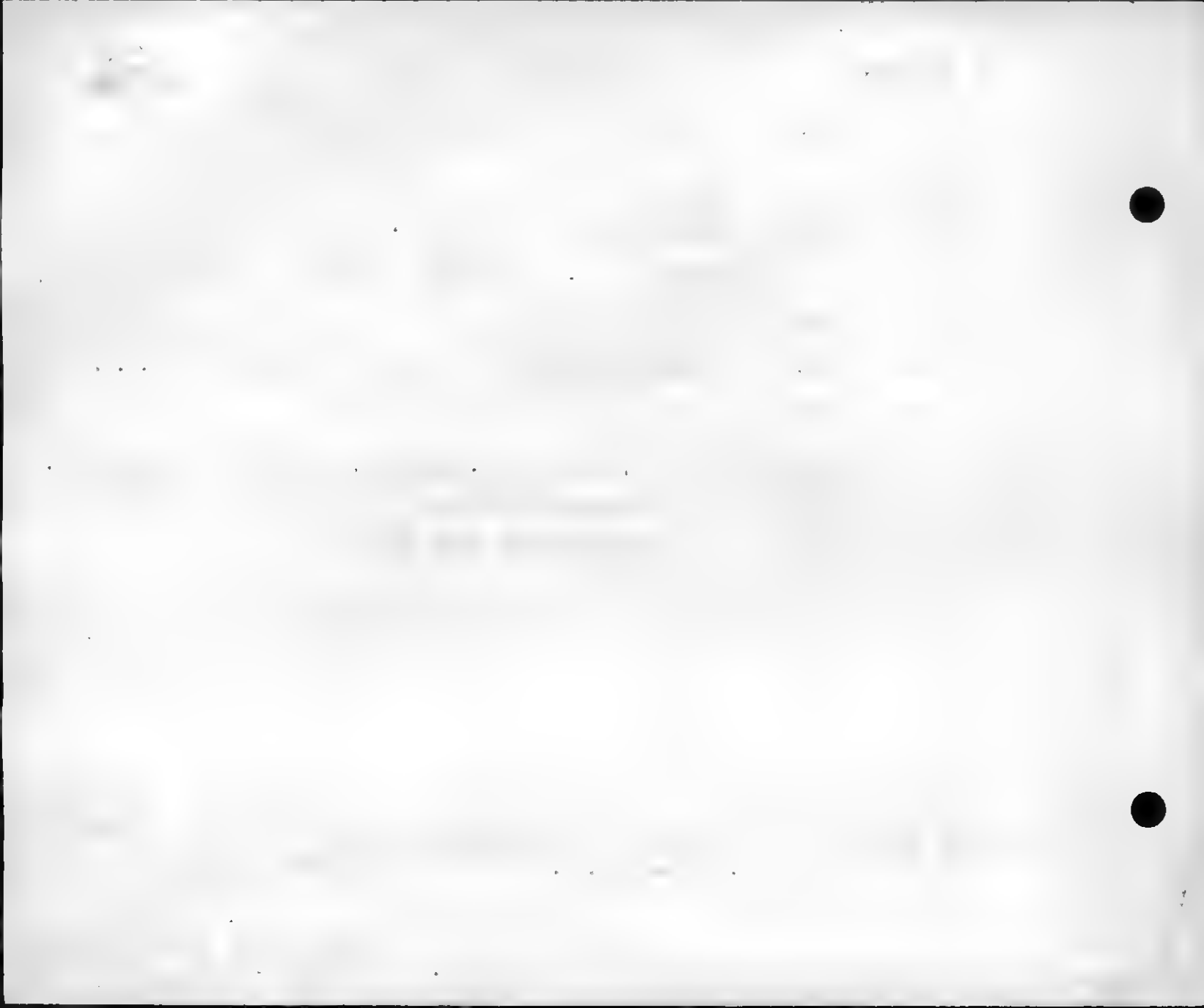
**04789**

**CERTIFICATE OF DEATH**

**04789**

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>_____</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c LENGTH OF STAY in 1b <b>10 DAYS</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21224</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>219 N. LINWOOD AVENUE</b>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK J. KOEHLER</b>				4 DATE OF DEATH Month Day Year <b>APRIL 17 1967</b>			
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/9/96</b>		9 AGE (In years last birthday) Yrs <b>70</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SPECIAL POLICE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DETECTIVE AGENCY</b>		11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW KOEHLER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA MURPHY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218 07 77 14</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b> H200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/7/67</b> , 19 <b>67</b> to <b>4/17/67</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/17/67</b> , 19 <b>67</b> , and that death occurred at <b>1:40 PM</b> from causes and on the date stated above.							
22a SIGNATURE <b>J. D. Talbert</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <b>4/18/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>				22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4/20/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL</b>		23d LOCAT ON (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Joseph H. Zannino</b>				25a RECORD BY REGISTRAR <b>APR 21 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS <b>ZANNINO FUNERAL HOME</b>				25c REGISTRAR'S SIGNATURE <b>257 S. CONKLING ST. BALTIMORE, MD.</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in a casket, within 72 hours after death.



04790

CERTIFICATE OF DEATH

04790

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>				d. STREET ADDRESS <u>3503 Hilton Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH L. KOGAN</u>				4. DATE OF DEATH Month Day Year <u>April 24, 19 67</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH	
9. AGE (in years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>		11 BIRTHPLACE (County & State or foreign country) <u>Russia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LEON ? Samuel Kogan</u>				14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>UNKNOWN</u>		17. INFORMANT Address <u>Mr. Sylvan B. Kogan, 6014 Woodcrest Avenue</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443 X Cardio-Respiratory Failure, Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C V H D</u> (c) <u>Gen &amp; Cerebral Arteriosclerosis</u>							INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Dec 5, 1960</u> to <u>April 24, 19 67</u> that (I) (we) last saw the deceased alive on <u>April 24, 19 67</u> , and that death occurred at <u>6:25 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>Willard Applefeld</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b DATE SIGNED <u>4-24-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. Willard Applefeld</u>				22d ADDRESS <u>5901 Park Heights Avenue</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>4/27/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24 FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>				25a REC'D BY REGISTRAR <u>MAY 1 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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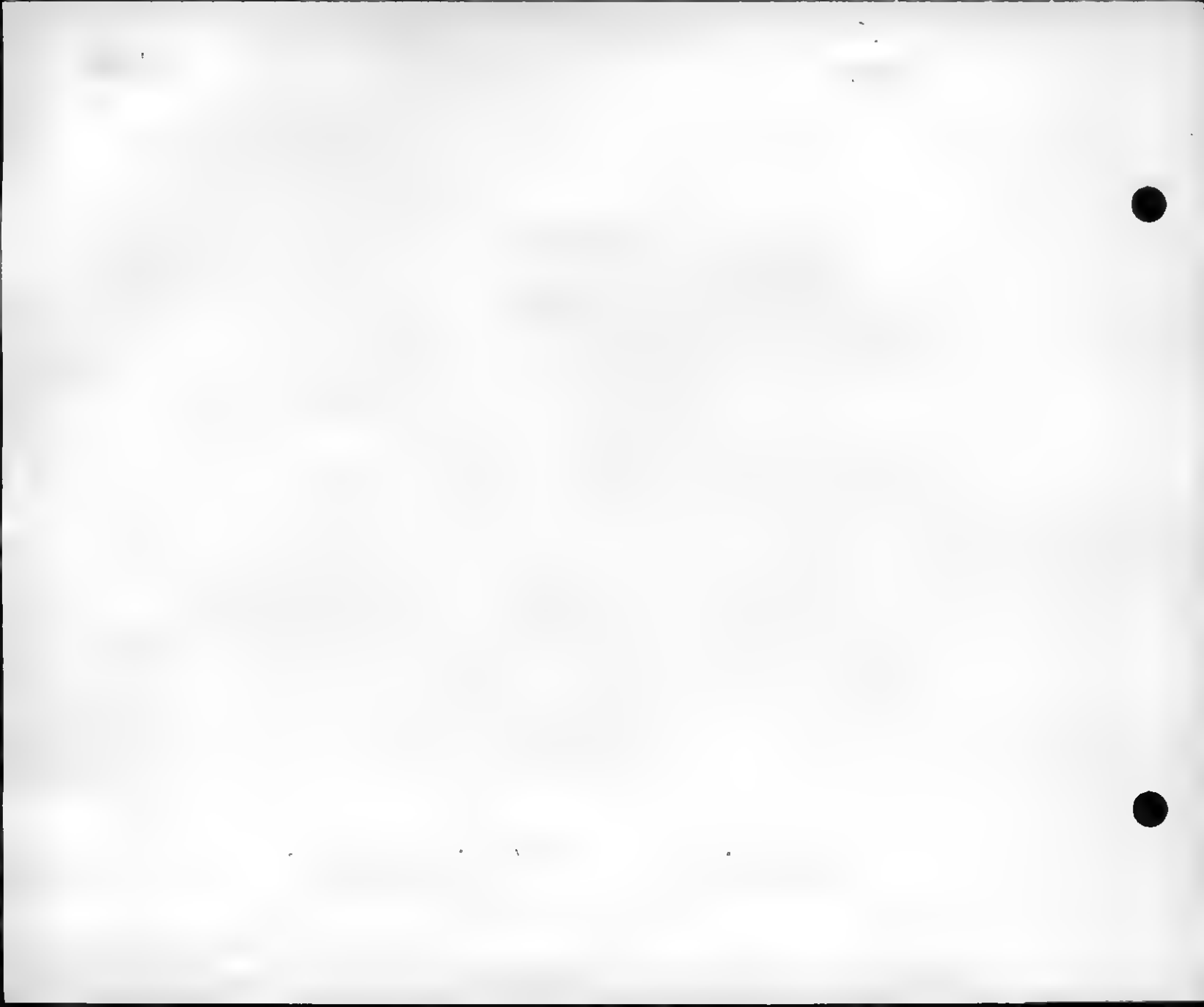
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04791

CERTIFICATE OF DEATH

04791

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Baltimore</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2613 Taylor Ave</b>		e. STREET ADDRESS <b>2613 Taylor Ave</b>	
3 NAME OF DECEASED (Type or print) First <b>Julia M</b> Middle <b>Kolb</b> Last <b></b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20 1882</b>
9 AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius Wirth</b>		14. MOTHER'S MAIDEN NAME <b>Martha Faulk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b></b>	
17. INFORMANT <b>Mrs Lillian M Monninger</b>		Address <b>2613 Taylor Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma colon</b> <b>1000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 1956, to <b>April 24</b> , 1967, that (I) (we) last saw the deceased alive on <b>April 22</b> , 1967, and that death occurred at <b>5 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Stephen J. Van Lill III</b>		22b. DATE SIGNED <b>April 24</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen J. Van Lill III, M.D.</b>		22d. ADDRESS <b>3506 N. Calvert 21218</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>April 25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

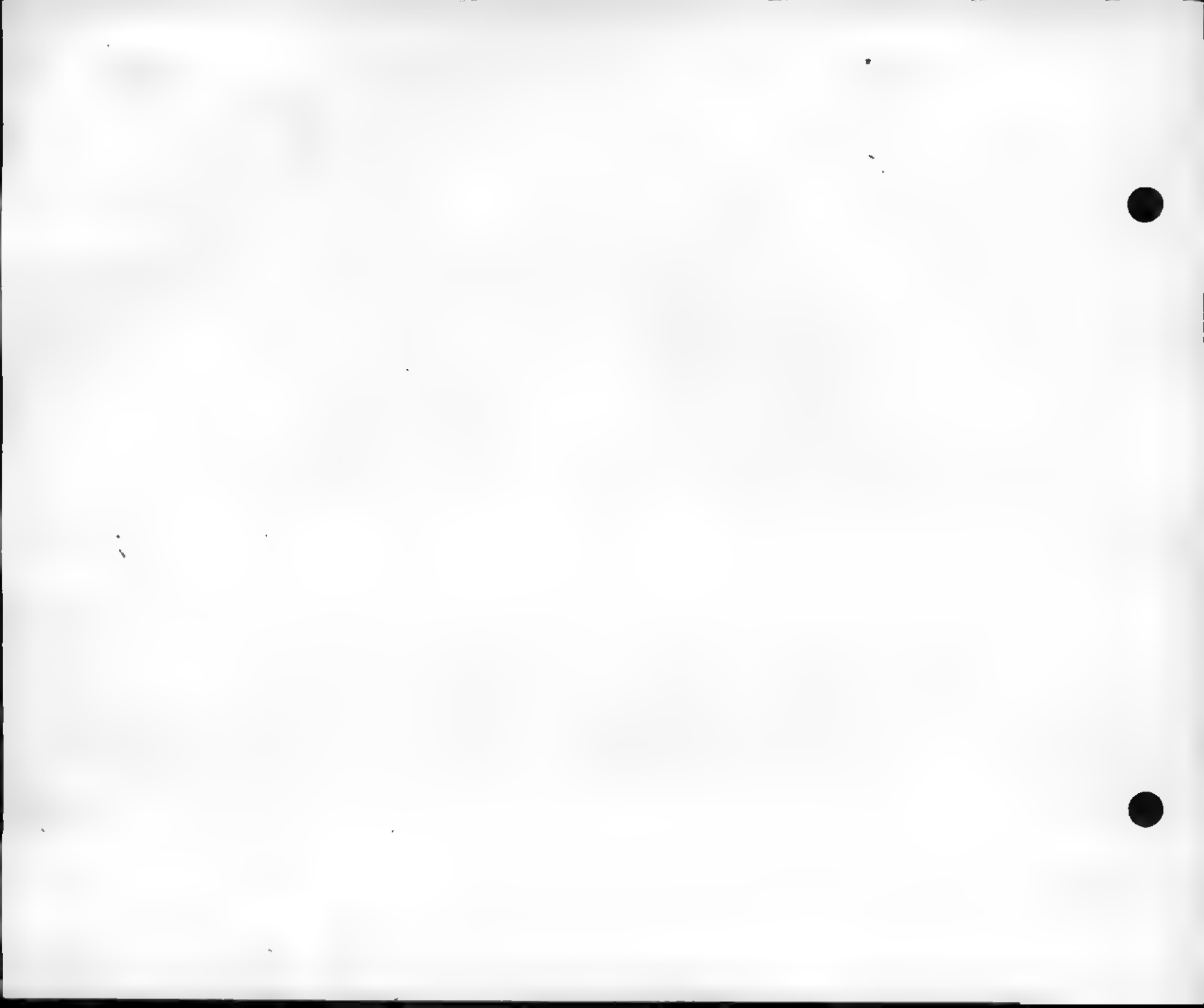
04792

04792

1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c LENGTH OF STAY IN 1b <u>BALTIMORE 21229</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT CONV. HOME</u>		e STREET ADDRESS <u>124 MALBROOK RD</u>	
3 NAME OF DECEASED (Type or print) <u>AMELIA M. KROEDEL</u> First Middle Last		4 DATE OF DEATH <u>APRIL 27</u> 19 <u>67</u> Month Day Year	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/92</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WM. HICHLER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SCHMIDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS JOSEPH RUTH</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary</u> DUE TO (b) <u>Carcinoma of Ovary (Primary)</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>67</u> , to <u>April 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 20</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>J. Nelson McKay</u>		22b DATE SIGNED <u>April 28 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>J. NELSON MCKAY, M.D.</u>		22d ADDRESS <u>6014 EDMONDSON AVE</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>5/1/67</u>	<u>CATHEDRAL</u>	<u>BALTO. MD.</u>
24 FUNERAL DIRECTOR <u>E. S. MALNAB</u>		25a REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>	
ADDRESS <u>301 FREDERICK RD 21228</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

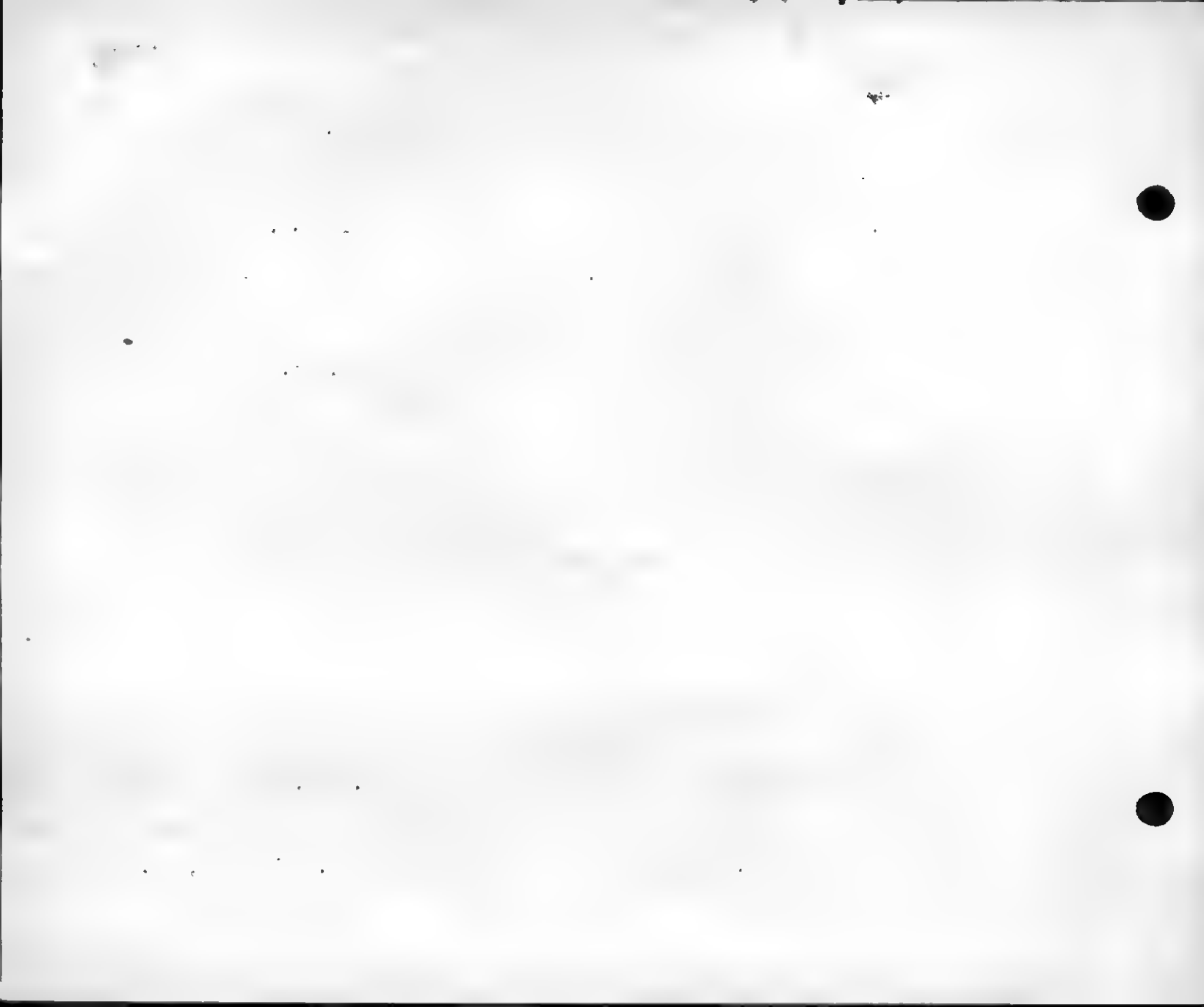
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04793

CERTIFICATE OF DEATH

04793

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21218</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1206 Cochran Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Caroline A. Kuehn</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/95</b>	9. AGE (in years last birthday) <b>71</b> yrs	IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b>		IF UNDER 24 HRS. Hours <b>_____</b> Min <b>_____</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick W. Frederick</b>				14. MOTHER'S MAIDEN NAME <b>Caroline A. Zeifle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William F. Kuehn, 1312 Northview Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Anterior Myocardial Infarction</b> DUE TO (c) <b>_____</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>_____</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1967</b> , to <b>April 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1967</b> , and that death occurred at <b>8:20 PM</b> , from causes and on the date stated above							
22a. SIGNATURE 				22b. DATE SIGNED <b>April 17 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Ismael O. Jamora</b>	
22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, Md.</b>			
24. FUNERAL DIRECTOR <b>Ulrich Funeral Home 4210 Belair Road.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

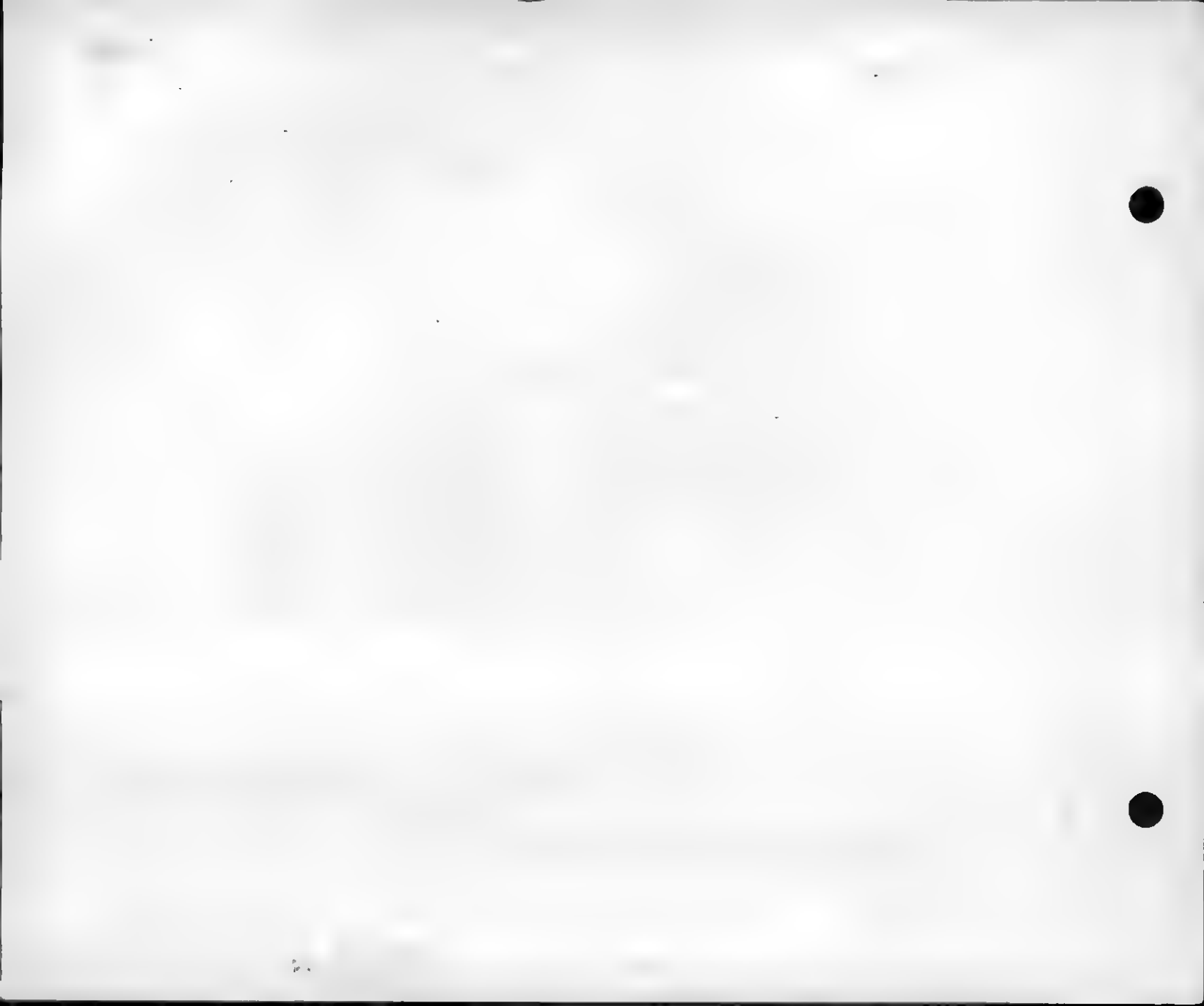
04794

Item #9 Film #3448 5/13/67 92

CERTIFICATE OF DEATH

04794

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2209 Fleetwood Ave. - Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>2209 Fleetwood Ave - Baltio</u>			
3. NAME OF DECEASED (Type or print) <u>KUNZE</u> <u>Augusta</u> <u>Schadna</u> <u>Kunze</u>				4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/1/97</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John HAGEDORN</u>			
14. MOTHER'S MAIDEN NAME <u>Thompson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>_____</u>			
16. SOCIAL SECURITY NO <u>_____</u>				17. INFORMANT <u>PT. CHART.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-18-</u> , 19 <u>67</u> , to <u>4/22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-22-</u> 19 <u>67</u> and that death occurred at <u>11:45AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>R. K. CHILLAR</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>RAM K CHILLAR</u>				22d. ADDRESS <u>CTR BALTO MED CENTER</u> <u>BALTIMORE MD 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>Eddeemane</u>		ADDRESS <u>7007 6067 Hwy</u>		25a. REC'D BY REGISTRAR <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04795

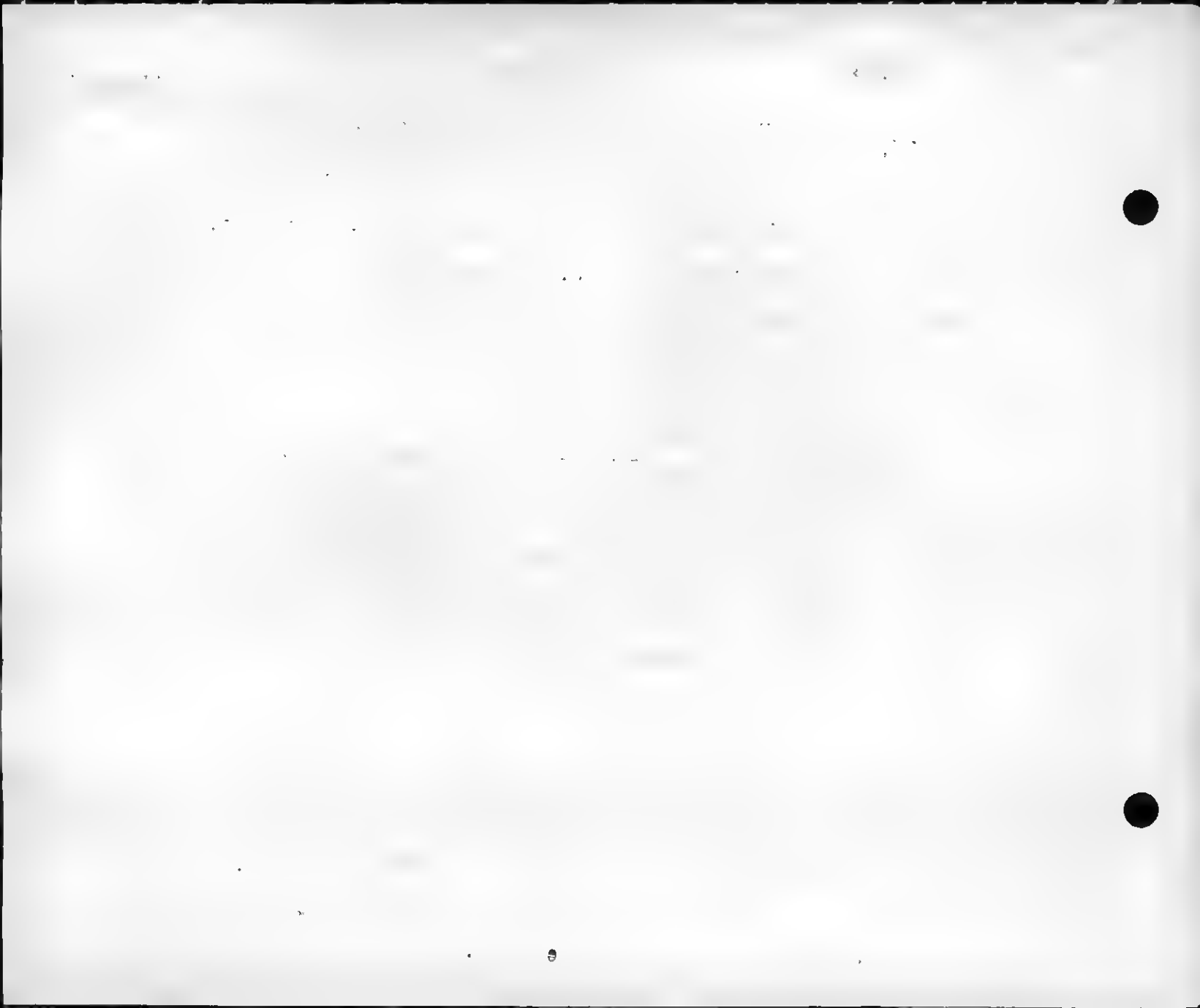
CERTIFICATE OF DEATH

04795

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shady Nook Nursing Home</b>		e. STREET ADDRESS <b>2212 N. Charles St.</b>	
3 NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>J.</b> Last <b>Lassalle</b>		4 DATE OF DEATH Month <b>4</b> Day <b>17</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/3/1872</b>
9a. AGE (In years last birthday) <b>95</b> yrs		9b. IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min <b>_____</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Lassalle</b>		14. MOTHER'S MAIDEN NAME <b>Anna Corliss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>_____</b>		16. SOCIAL SECURITY NO <b>_____</b>	
17. INFORMANT <b>Dorothy M. Canton</b>		Address <b>_____</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO <b>Cerebral Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>&amp; Atherosclerosis</b> (c) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>		19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>_____</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>_____</b> a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>	20f. (City or town) (County) (State) <b>_____</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4, 1956</b> , to <b>April 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/7</b> 1967, and that death occurred at <b>7:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John C. Healy</b>		22b. DATE SIGNED <b>4/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John Healy</b>		22d. ADDRESS <b>2002 Francis Ave.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a. RECD BY REGISTRAR <b>APR 19 1967</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04796

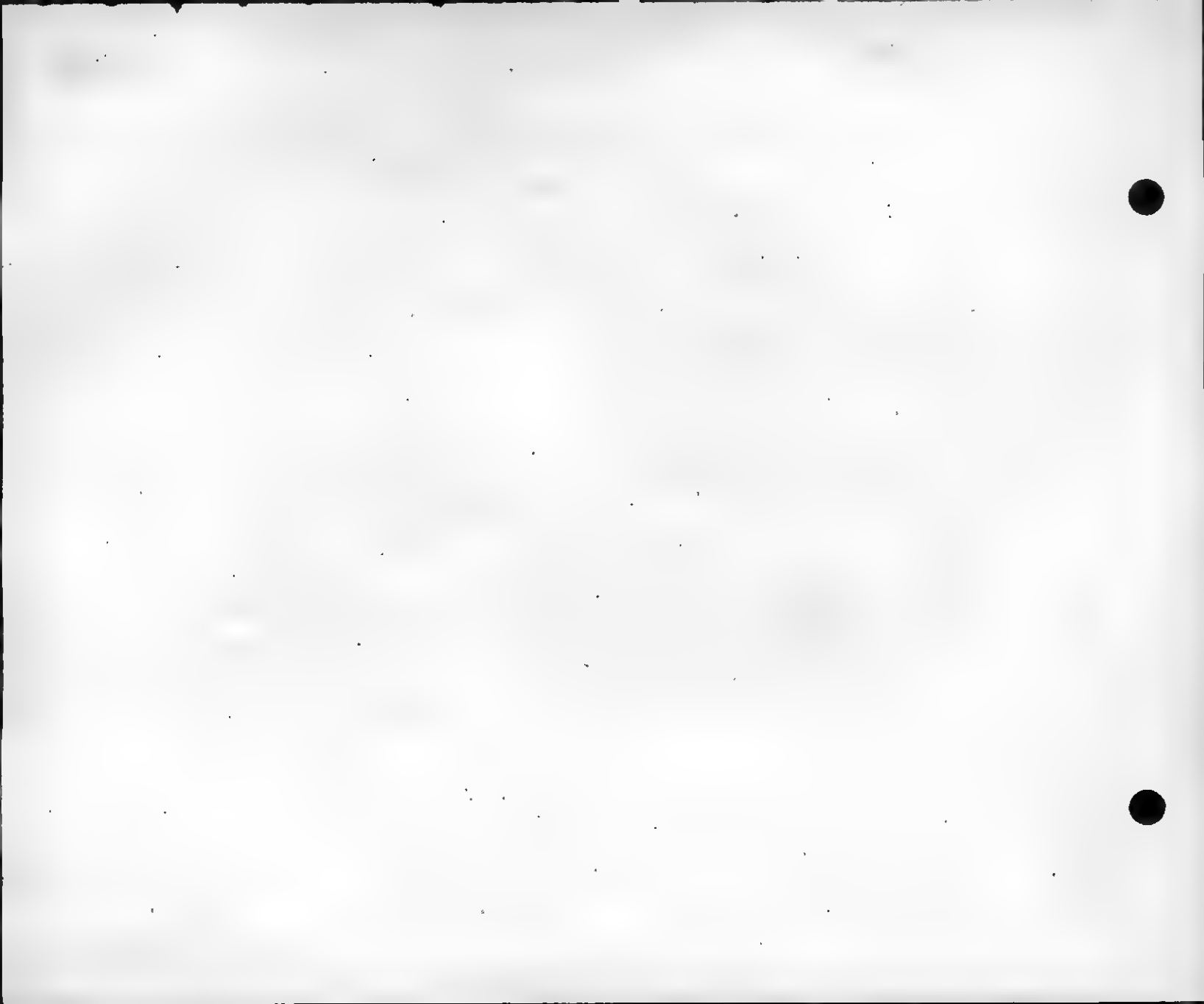
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04796

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenspring Avenue</u>		d. STREET ADDRESS <u>Ridge Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lillie Eleanor Ledley</u>		4. DATE OF DEATH <u>April 9, 1967</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1878</u>
9. AGE (in years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>John W. Hoffman</u>		15. MOTHER'S MAIDEN NAME <u>Georgiana Williams</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>None</u>	
18. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rt. Breast</u> X DUE TO (b) <u>metastases to lungs</u> DUE TO (c) <u>cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month <u>April</u> Day <u>9</u> Year <u>1967</u> Hour <u>11</u> a.m. <u>00</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1940</u> to <u>4-9-1967</u> , that (I) (we) last saw the deceased alive on <u>4-8-67</u> and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James O. Saffell MD</u>		22b. DATE SIGNED <u>4-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James O. Saffell MD</u>		22d. ADDRESS <u>Reisterstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Falls Id. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Lutherville, Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04797

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04797

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN b <b>14 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GBMC</b>		d. STREET ADDRESS <b>8700 Raven Drive Apt. A</b>	
3 NAME OF DECEASED (Type or print) East <b>Lela</b> Middle <b>Clyde</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>4</b> Day <b>19</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/03/99</b>
9. AGE (In years lost birthday) <b>67</b> yrs		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Joseph Burchett</b>		14 MOTHER'S MAIDEN NAME <b>Cora Ellen Hill</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>1</b>	
17. INFORMANT <b>Mr. Walter Lee, Same as # Two</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary Shock and Pneumonia</b> DUE TO <b>Ventricular Fibrillation and Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arrest</b> (c) <b>Arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 days</b> <b>Sudden</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>During Abdominal Surgery</b>	
20c. TIME OF INJURY Month, Day, Year <b>12 p.m. April 11 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Hospital</b>		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		22. DATE SIGNED <b>4/19/67</b>	
EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hereford Baptist Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hereford, Baltimore Co., Md.</b>
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>		25a. REC'D BY REGISTRAR <b>APR 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

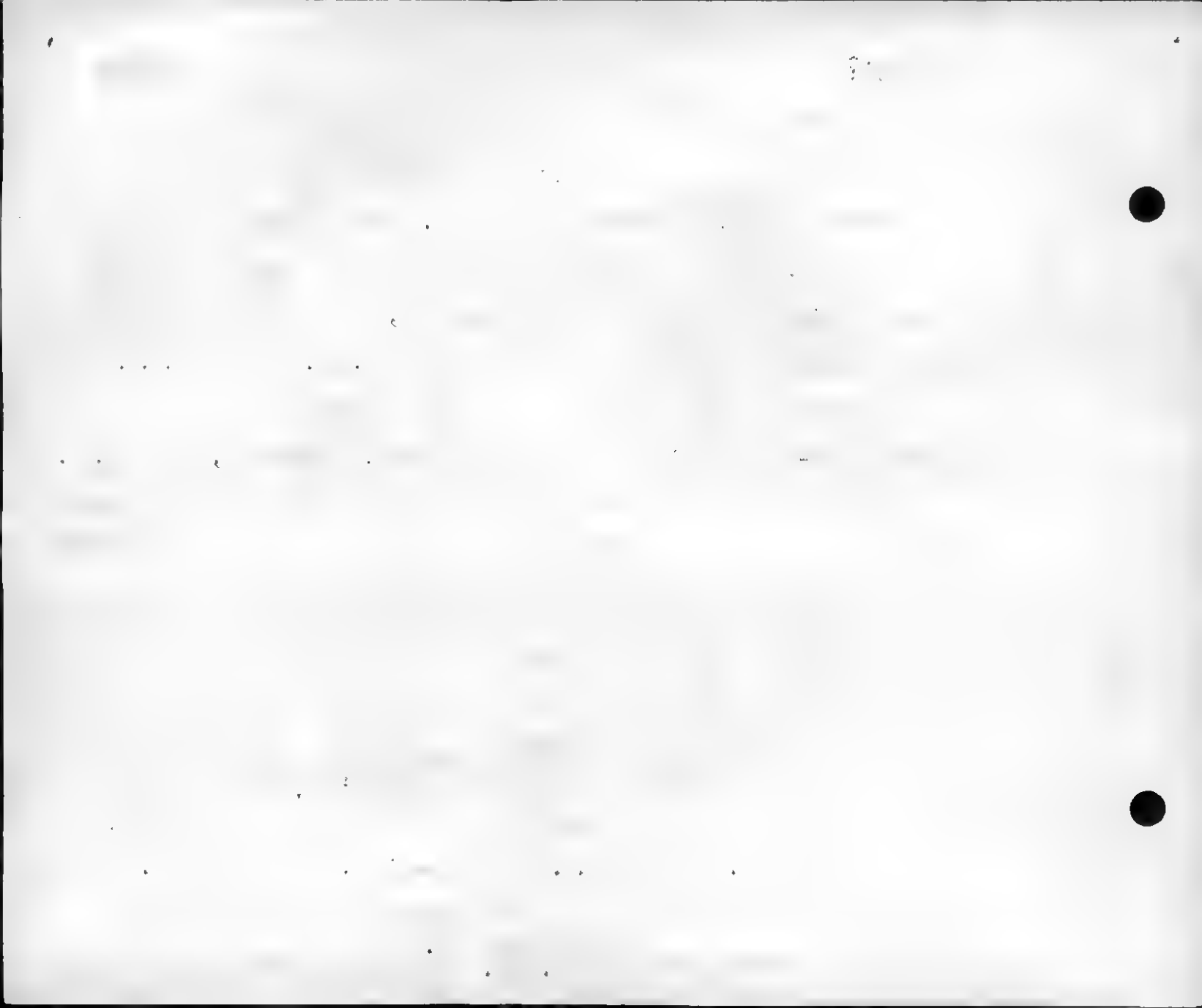
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04798

CERTIFICATE OF DEATH

04798

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a STATE <b>Maryland</b> b COUNTY <b>---</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c LENGTH OF STAY in 1b <b>11 days</b>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e STREET ADDRESS <b>6 N. Maderia Street</b>	
3 NAME OF DECEASED (Type or print) First <b>PHILIP</b> Middle <b>EARL</b> Last <b>LEESON, Sr.</b>		4 DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 10, 1931</b>
9 AGE (in years last birthday) <b>36</b> yrs		10 UNDER 1 YEAR Months <b>---</b> Days <b>---</b>	
10a USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <b>Assembly Operator</b>		10b KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Floyd Leeson</b>		14 MOTHER'S MAIDEN NAME <b>Mabel Malone</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes PL-28</b>		16 SOC. A. SECURITY NO. <b>217 26 15 84</b>	
17 INFORMANT <b>Clinical Rcds. VA Hospital, Ft Howard, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b> <b>5811</b> DUE TO (Card, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <b>LAENNEC'S CIRRHOSIS</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>---</b>	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 10</b> , 19 <b>67</b> , to <b>April 21</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 21</b> , 19 <b>67</b> , and that death occurred at <b>4:30 P.</b> , from causes and on the date stated above.			
22a SIGNATURE <i>Paulino D. Deocampo</i>		22b DATE SIGNED <b>4/22/67</b>	
22c PHYSICIAN'S NAME (Type) <b>PAULINO D. DEOCAMPO, M.D.</b>		22d ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>4-25-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	23d LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Hartley Miller Funeral Home</b>		25a REC'D BY REGISTRAR <b>2334 Jefferson St. Balto., Md.</b>	
		25b REGISTRAR'S SIGNATURE <i>Charles George</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

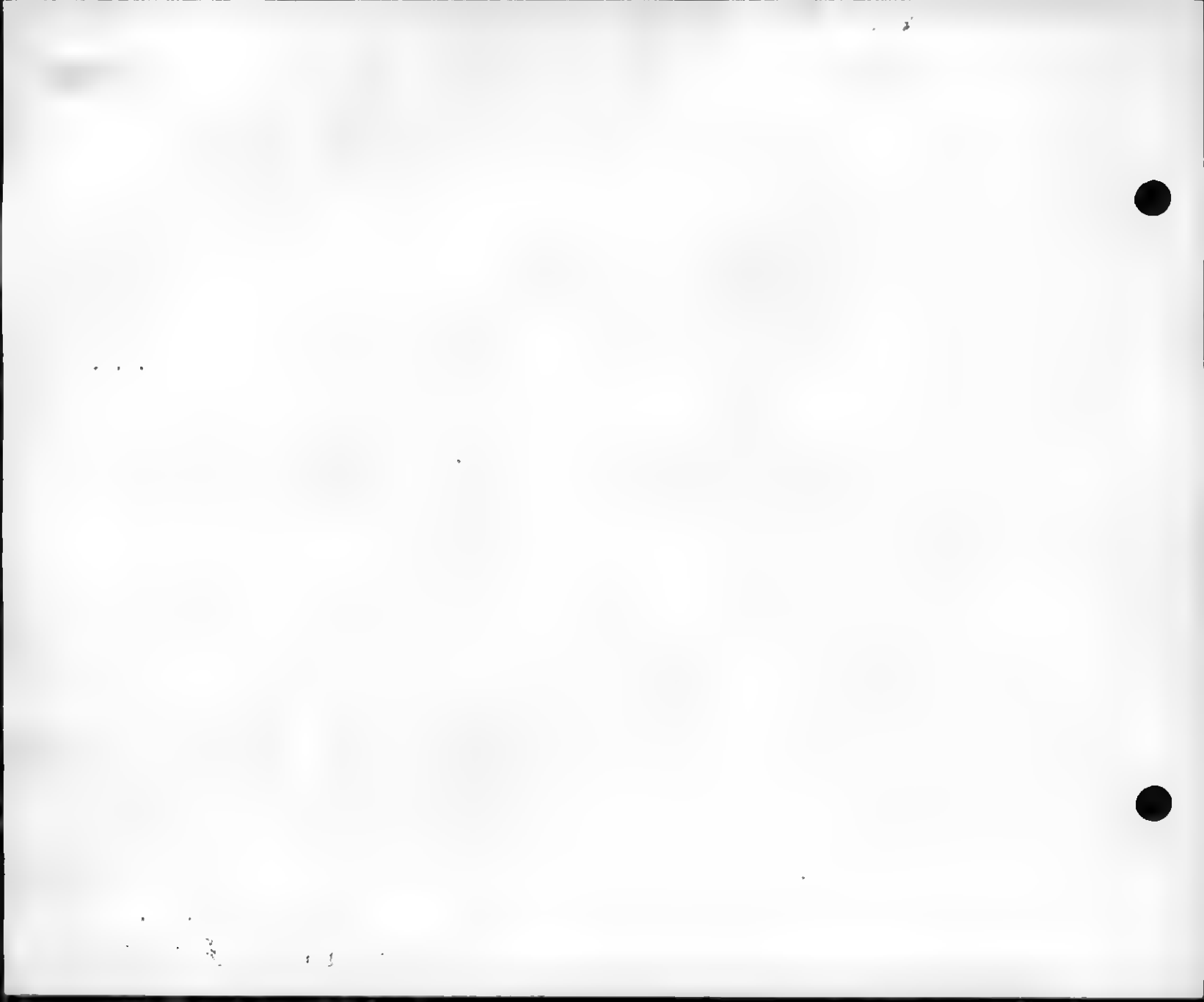
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04793

04799

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE <b>Maryland</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowleys Quarters</b>		c LENGTH OF STAY IN 1b <b>Bowleys Quarters</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 15, Box 560</b>		d STREET ADDRESS <b>Route 15, Box 560</b>	
3 NAME OF DECEASED (Type or print) <b>William P. E. Leicht</b>		4 DATE OF DEATH Month <b>April</b> , Day <b>5</b> , Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 17, 1890</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Producer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Theatres</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Adam P. Leicht</b>		14 MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>219-32-3216</b>	
17 INFORMANT <b>Wm. P. Leicht</b>		Address <b>Route 15, Box 56- 21220</b>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>H-S-C-V-DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>6800 Mornington Road</b>		22. DATE SIGNED <b>4/6/67</b>	
23a BURIAL & CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/8/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Co. Md.</b>	
24 FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road.</b>		25a REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





1-6  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only pages 1, 2, and 3 are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or reinterment, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

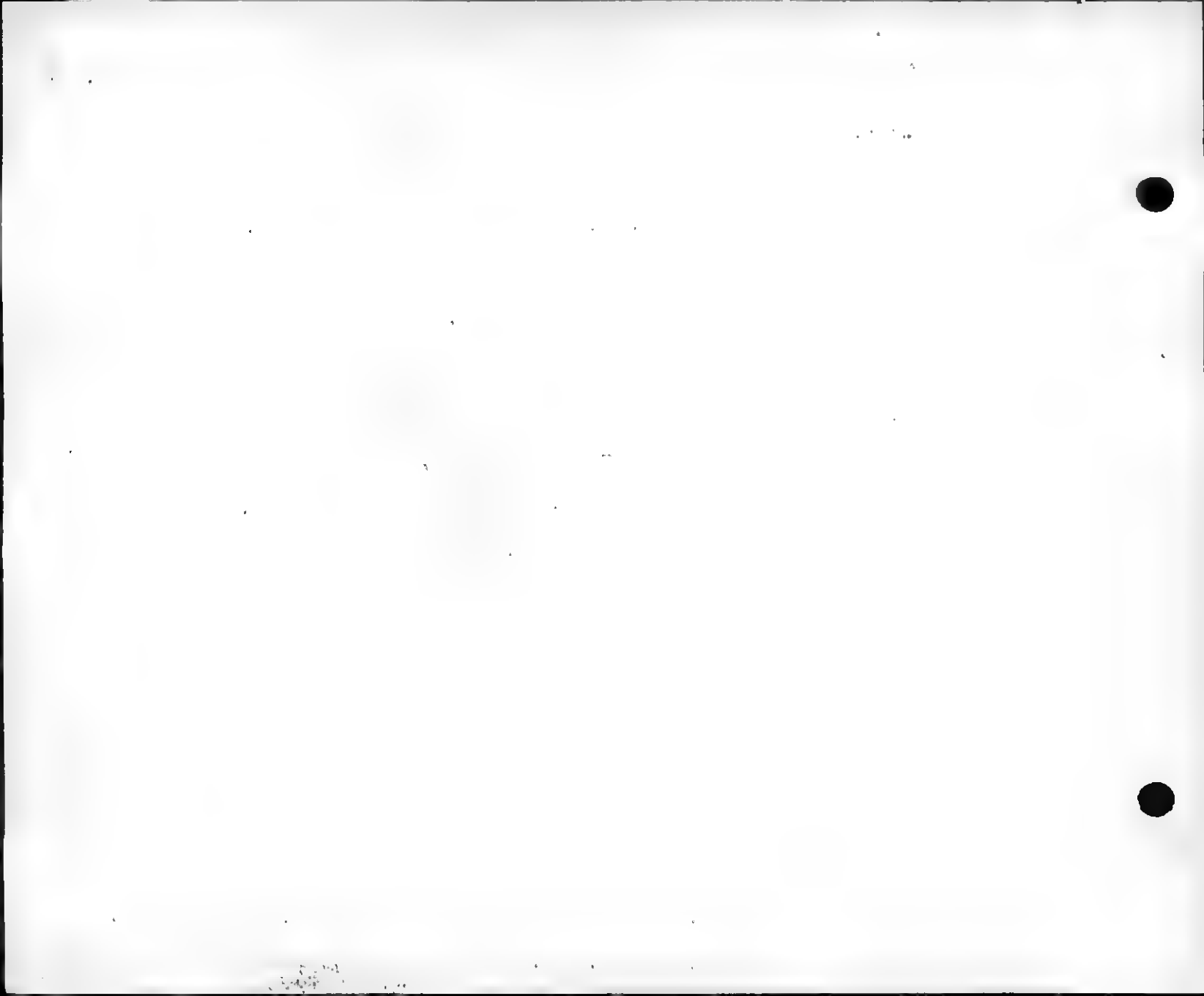
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04800

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04800

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson, Md.</b>			c LENGTH OF STAY IN 1d <b>2 days</b>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore City</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>				d STREET ADDRESS <b>9300 Carney Avenue</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond Kemper Leonhardt</b>				4 DATE OF DEATH Month Day Year <b>4/ 27 19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/4/03</b>		9 AGE (In years last birthday) <b>63 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min <b>63</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Henry Leonhardt</b>				14 MOTHER'S MAIDEN NAME <b>Barbara Kemper</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-03-3822</b>		17 INFORMANT Address <b>Records, Mount Wilson State Hospital</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic R. Obstructive Resp. Disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <b>Chronic Cor Pulmonale</b> (c) <b>Chronic Bronchitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardio Vascular disease</b> <b>5 yrs.</b>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>None.</b>					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>None.</b>		20f (City or town) (County) (State) <b>Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D.D. CAPLES</b>		EXAMINER'S NAME (Type) <b>D.D. CAPLES</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>4/27/67</b>	
23a BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/29/67.</b>		23c NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a REC'D BY REGISTRAR DATE <b>APR 28 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

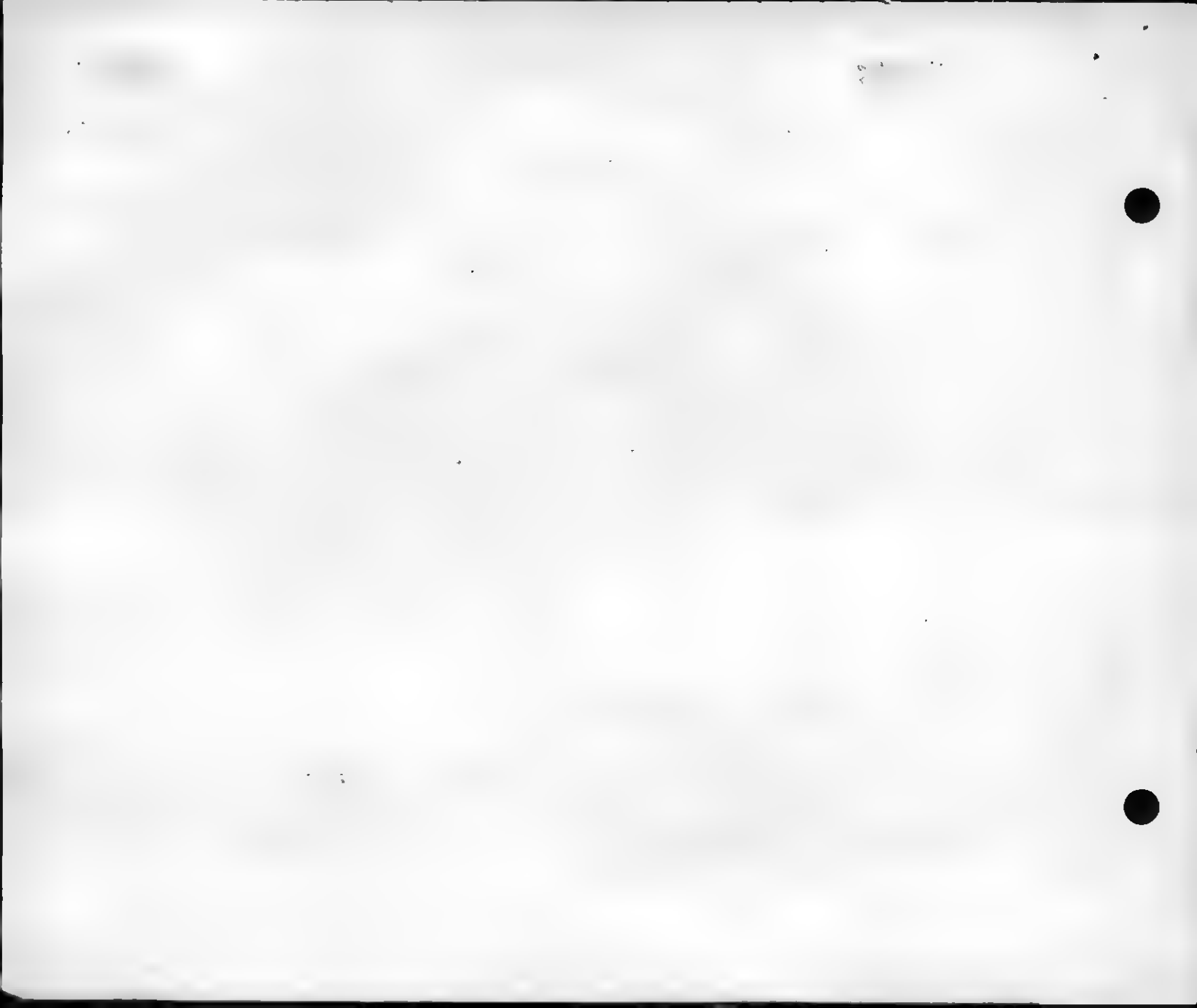
**04801**

**CERTIFICATE OF DEATH**

**04801**

**TO HOSPITAL ON ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>2 Years</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				d. STREET ADDRESS <u>6908 Marsue Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6908 Marsue Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>Levin</u> Last <u>Levin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postman</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Levin</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Linden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-16-5375</u>		17. INFORMANT Address <u>Mrs. Augusta Levin 6908 Marsue Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Testis, Generalized</u> DUE TO (b) <u>Carcinoma of prostate</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVA. BETWEEN ONSET AND DEATH <u>3 mo</u> <u>1 1/2 yrs</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>Apr</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr 14</u> , 19 <u>67</u> , and that death occurred at <u>5:58</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Irvin Sauber</u> M.D.				22b. DATE SIGNED <u>Apr 16, 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Irvin Sauber</u>	
22d. ADDRESS <u>6905 Park Heights Avenue</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Hamedrosh Hagodol</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. 6010 Reisterstown Road</u>				25a. REC'D BY REGISTRAR DATE <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04802

CERTIFICATE OF DEATH

04802

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN TB <u>14 Yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1260 Locust Ave</u>				d. STREET ADDRESS <u>1260 Locust Ave</u>			
3 NAME OF DECEASED (Type or print) <u>Jean E. Link</u>				4 DATE OF DEATH <u>April 4 1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>September 15 1924</u>	9 AGE (In years last birthday) <u>42</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11 BIRTHPLACE (County, State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward J. Peach</u>				14. MOTHER'S MARYEN NAME <u>Mary Brewer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u>no</u>		17 INFORMANT Address <u>Carville E. Link 1260 Locust Ave</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix</u> DUE TO <u>General Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>General Carcinomatosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> , to <u>April 1967</u> that (I) (we) last saw the deceased alive on <u>April 1967</u> , and that death occurred at <u>3:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Brumbaugh</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bruce B. Brumbaugh</u>				22d. ADDRESS <u>5609 Main St, Ellicott City Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fountain Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Amber Inc. 1328 Sulphur Sp Rd</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04803

CERTIFICATE OF DEATH

04803

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> c. LENGTH OF STAY IN IT <u>18 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3033 CALIFORNIA AVE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> d. STREET ADDRESS <u>3033 CALIFORNIA AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Vennie</u> First <u>Rose</u> Middle <u>Longo</u> Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-18-1899</u> 9. AGE (In years last birthday) <u>68</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPL. (County & State, or foreign country) <u>PENN.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>27</u> Year <u>1967</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>			
<b>13. FATHER'S NAME</b> <u>Thomas M. LO</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>PATTERSON</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>Mrs P Hyatt Glass</u> Address <u>Same</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>170X Acute Circulatory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis.</u> (c) <u>Adenocarcinoma Breast.</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>  </u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office, etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/8</u> , 19 <u>66</u> , to <u>4/28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4/27</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> P.M. from causes and on the date stated above. <b>22a. SIGNATURE</b> <u>Frank T. Kasik Jr</u> M.D. <b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/> <b>22b. DATES SIGNED</b> <u>4/28/67</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>FRANK T. KASIK JR</u> <b>22d. ADDRESS</b> <u>9005 HARTWOOD RD</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>5-1-1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GARDEN OF FAITH</u> <b>23d. LOCATION (City or town)</b> (County) (State) <u>BALTO MD</u>				<b>24. FUNERAL DIRECTOR</b> <u>CHAR F EVANS JR</u> <u>8802 HARTWOOD RD</u> <b>25a. REC'D BY REGISTRAR</b> <u>MAY 1 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. J...</u>			





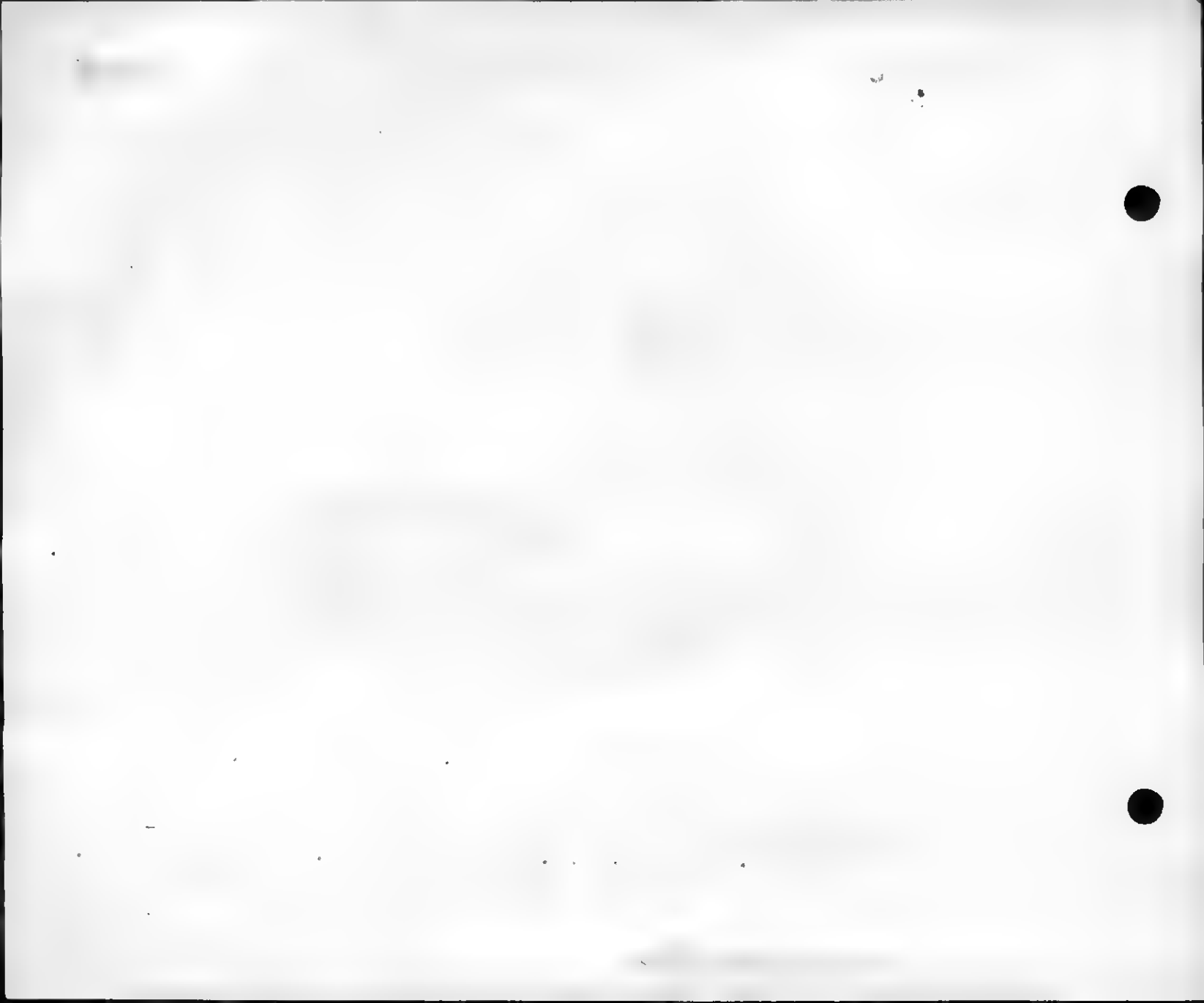
04804

04804

1 PLACE OF DEATH a COUNTY <u>BA/TO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution a STATE <u>Md</u> b COUNTY <u>BA/TO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERS TOWN</u>		c LENGTH OF STAY IN 1b <u>REISTERS TOWN</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>913 Lindellen Ave</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>MAE</u> Last <u>LUTZ</u>		4 DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JAN. 18, 1912</u>
9 AGE (In years last birthday) <u>55</u> yrs		10 UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	10 UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Cafeteria</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Newberry, York PA.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13 FATHER'S NAME <u>ROY WINTER</u>		14. MOTHER'S MAIDEN NAME <u>SARA KOLTZ</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>203-10-1520</u>	
17 INFORMANT <u>GLORIA L. WHAREN</u>		Address <u>913 Lindellen Ave</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition (vomiting dehydration)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Myeloma</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 6</u> , 19 <u>67</u> to <u>Apr. 12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Apr. 12</u> , 19 <u>67</u> , and that death occurred at <u>9:06 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Martin E. Strobel</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>4-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d ADDRESS <u>48 Main St. Reisterstown, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>April 14, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>SALEM, CEM</u>	23d LOCATION (City or Town) (County) (State) <u>ETTERS RD #1 PA.</u>
24. FUNERAL DIRECTOR <u>Henry F. Eckhardt</u>		25a. REC'D BY REGISTRAR DATE <u>APR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

VR A15 (4)  
25M 1/67

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

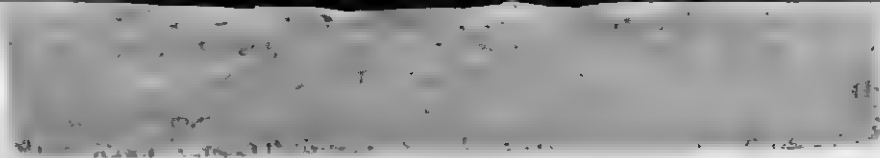
## CERTIFICATE OF DEATH

34836

D4836

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">b. STATE <u>MARYLAND</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <span style="float: right;">d. LENGTH OF STAY IN lb <u>MARYLAND</u></span> e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; not for use in case of admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>BALTO.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>919 VANDERWOOD ROAD</u>				d. STREET ADDRESS <u>919 VANDERWOOD RD</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>HELEN</u> <span style="float: right;">f. DATE OF DEATH</span> First Middle Last <u>MACFALSKI</u> <span style="float: right;">Month Day Year <u>4 17 1967</u></span>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>7-18-1890</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>76</u> <span style="float: right;">IF UNDER 1 YEAR</span> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>POLAND</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>MARION WISNIEWSKI</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>APOLONIA PURZYNSKI</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>213 10 1966A</u>			
<b>17. INFORMANT</b> <u>WANDA SYBOR</u> <span style="float: right;">Address <u>919 VANDERWOOD RD.</u></span>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Terminal)</u> DUE TO (b) <u>Cardio-Vascular Disease Compensated</u> DUE TO (c) <u>9 Months</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/23</u> <span style="float: right;">19<u>63</u> to <u>4/17</u> <span style="float: right;">19<u>67</u></span>, that (I) (we) last saw the deceased alive on <u>4/17</u> <span style="float: right;">19<u>67</u></span>, and that death occurred at <u>6:45 P.M.</u> <span style="float: right;">from the causes and on the date stated above</span> </span>		<b>22a. SIGNATURE</b> <u>Eliot W. Johnson</u> <span style="float: right;">M.D.</span>		<b>22b. DATE SIGNED</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Eliot W. Johnson</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>4-21-1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>HOLY ROSARY CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) <u>BALTO</u> <span style="float: right;">(State) <u>MD</u></span>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN M. WEBERSON INC 401 S. CHESTER ST.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 20 1967</u> <span style="float: right;">25b. REGISTRAR'S SIGNATURE <u>[Signature]</u></span>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

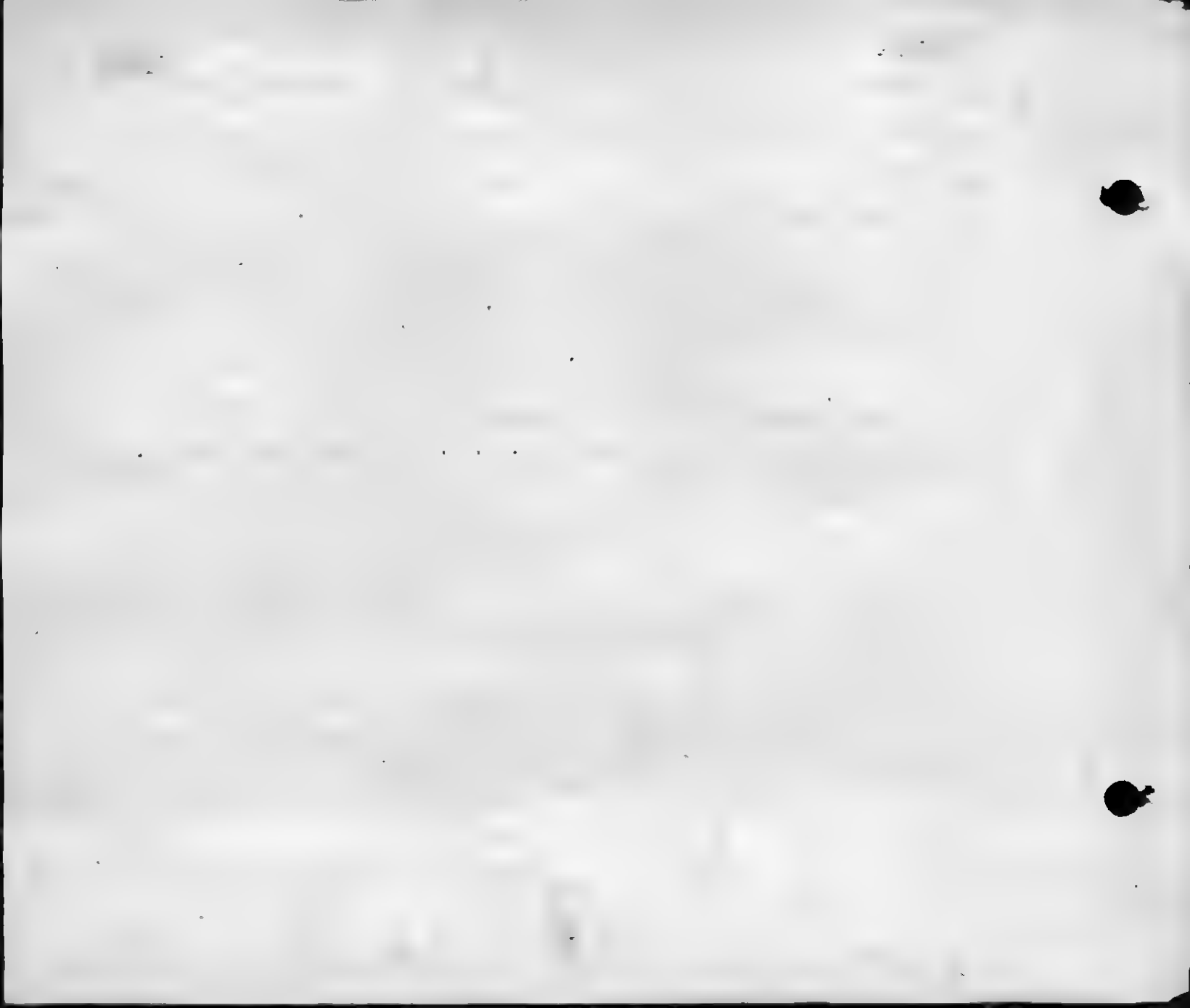
## CERTIFICATE OF DEATH

04805

04805

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glyndon</u> d. STREET ADDRESS <u>118 Butler Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>S.</u> Middle <u>Raymond</u> Last <u>MacLellan</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>20</u> Year <u>19 67</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 21, 1886</u>		<b>9. AGE</b> (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Md. Steel Prod.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> <u>Harry H. MacLellan</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nellie Maud James</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214-01-0325 A</u>				<b>17. INFORMANT</b> <u>Mrs. C. R. MacLellan</u> Address <u>118 Butler Rd.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>191X</u> DUE TO <u>Broncho-pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Generalized Atherosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year <u>1960</u> Hour <u>4</u> m. <u>19</u> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____													
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Apr 19 1967</u> <b>to</b> <u>Apr 22 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Apr 21 1967</u> <b>and that death occurred at</b> <u>10 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>William G. Helfrich</u> M.D.				<b>22b. ADDRESS</b> <u>5006 Roland Ave - Baltimore</u>				<b>22c. DATE SIGNED</b> <u>4/22/67</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>4/24/1967</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Cemetery</u>					
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Md.</u> (State) _____													
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. F. Tichner &amp; Son</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Charles J. Jones</u>				<b>25b. REGISTRAR'S SIGNATURE</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

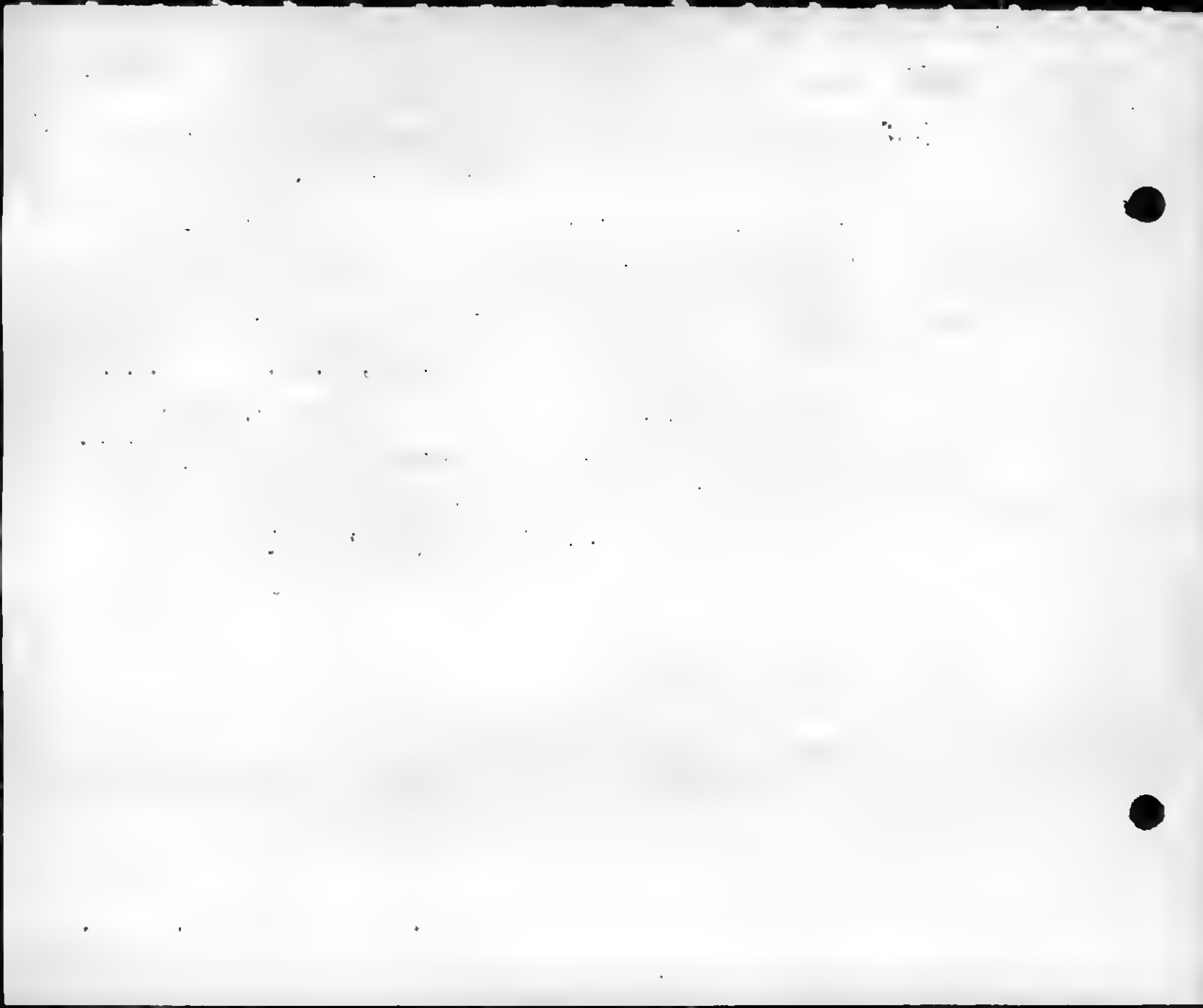
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04807

04806

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood Park</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood Park 21027</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt#16 Box 458 South River Drive</b>				d. STREET ADDRESS <b>Box 458 South River Drive</b>	
3. NAME OF DECEASED (Type or print) <b>HOWARD NELSON MAGSAMEN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-1914</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>52 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Rudolph Magsamen</b>		14. MOTHER'S MAIDEN NAME <b>Minnie E. Bevans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-6869</b>		17. INFORMANT Address <b>Chase, Md.</b> <b>Mrs Noreine Magsamen South River Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b></b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>THEO C. PATTERSON</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>4/3/67</b>	
EXAMINER'S NAME (Type) <b>THEO C. PATTERSON</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-5-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>	23d. LOCATION (City, town or county)	(State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Lossain Funeral Home 5401 Balan Road</b>		ADDRESS <b>(34)</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

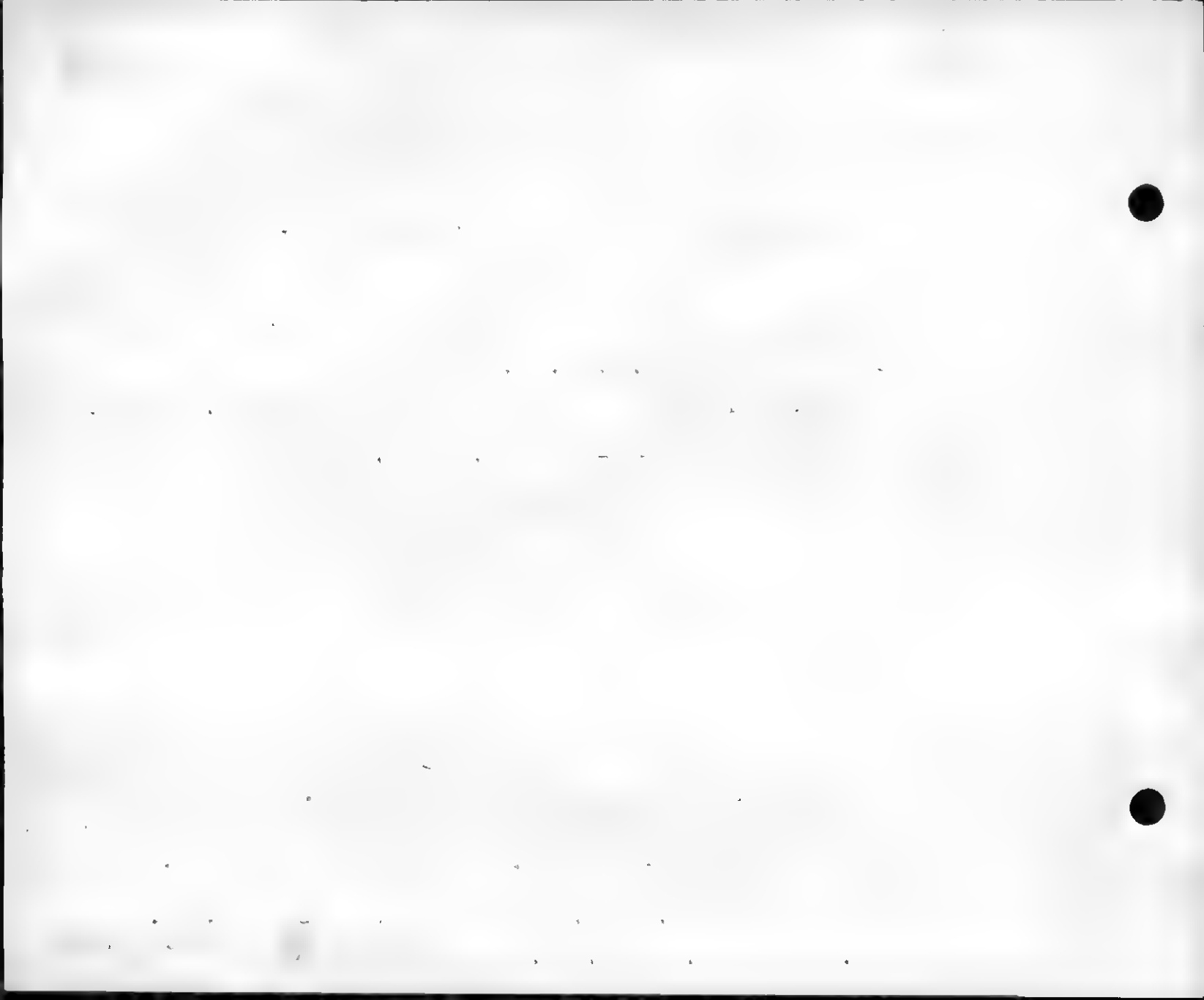
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04806

CERTIFICATE OF DEATH

04807

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN It			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e. STREET ADDRESS <b>1251 Halstead Rd.</b>			
3 NAME OF DECEASED (Type or print) First <b>Silver</b> Middle <b>Paul</b> Last <b>MAHER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> , Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>August 22, 1892</b>	9 AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. G. &amp; E. Co.</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas W. Maher</b>				14. MOTHER'S MAIDEN NAME <b>Matilda M. Wheeler</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16 SOCIAL SECURITY NO <b>212-05-4338</b>		17 INFORMANT <b>Mrs. Ann M. Maher</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Acute respiratory insufficiency</b> DUE TO <b>malignant tumor, left pleural cavity.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Broncho-genic carcinoma of the right lung with massive extension to right pleural cavity and metastasis to left lung.</b> (c) <b>Kyphoscoliosis.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 25,</b> 19 <b>67</b> , to <b>April 26,</b> 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 26,</b> 19 <b>67</b> , and that death occurred at <b>8:45M</b> , from causes and on the date stated above.							
22a SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>				22b ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		22c. PHYSICIAN'S NAME (Type)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/1/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04803

CERTIFICATE OF DEATH

04808

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>1802 Eutaw Place</u>	
3. NAME OF DECEASED (Type or print) <u>Ellen E. Malloy</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/96</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Joppa, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lomyer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Herbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34-2669</u>	
17. INFORMANT <u>Mrs. Dorothy Harmeyer, 1300 Philadelphia Rd.</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease &amp; congestive heart failure</u> DUE TO (b) <u>heart failure</u> DUE TO (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis; severe; decubitus ulcers.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> , 19 <u>67</u> to <u>4-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-30</u> , 19 <u>67</u> and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Angela Topp</u>		22b. DATE SIGNED <u>4-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANGELA TOPP</u>		22d. ADDRESS <u>BC MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Joppa Harford Md</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04803

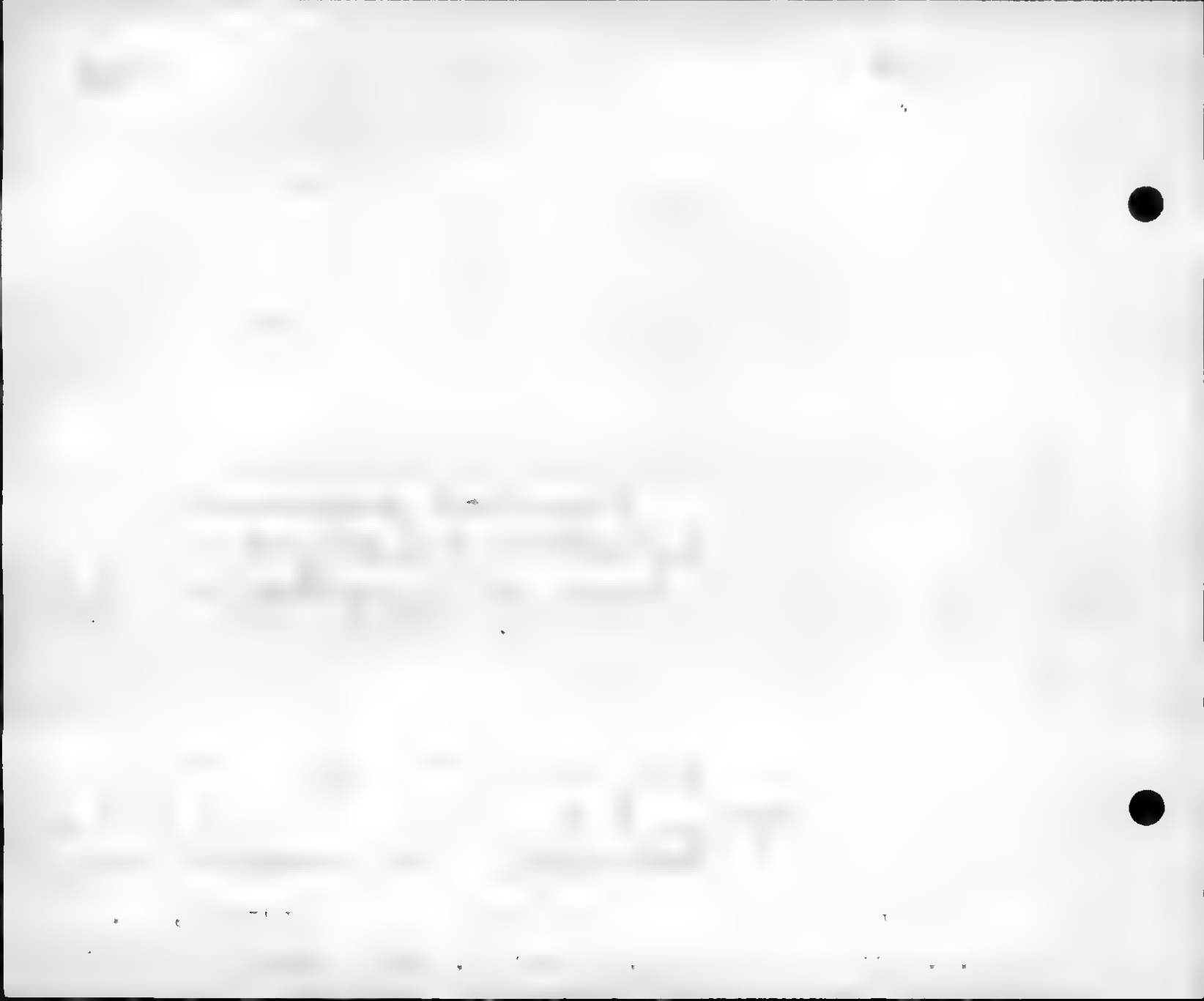
CERTIFICATE OF DEATH

04809

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY in 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		d. STREET ADDRESS <b>3333 N. CHARLES ST. 21218</b>	
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>E.</b> Last <b>MANSON</b>		4. DATE OF DEATH Month <b>4</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-15-93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SOCIAL SECURITY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS H. MANSON</b>		14. MOTHER'S MAIDEN NAME <b>SHOOT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>82-22-7319</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> DUE TO (b) <b>Dehydration secondary to</b> DUE TO (c) <b>Cancer of hypopharynx</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-26</b> , 19 <b>67</b> , to <b>4-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-26</b> , 19 <b>67</b> , and that death occurred at <b>11:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>V. R. BATOYON, M.D.</b>		22b. DATE SIGNED <b>4-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. R. BATOYON</b>		22d. ADDRESS <b>6701 N. Charles St., Balto, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Md.</b>
24. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

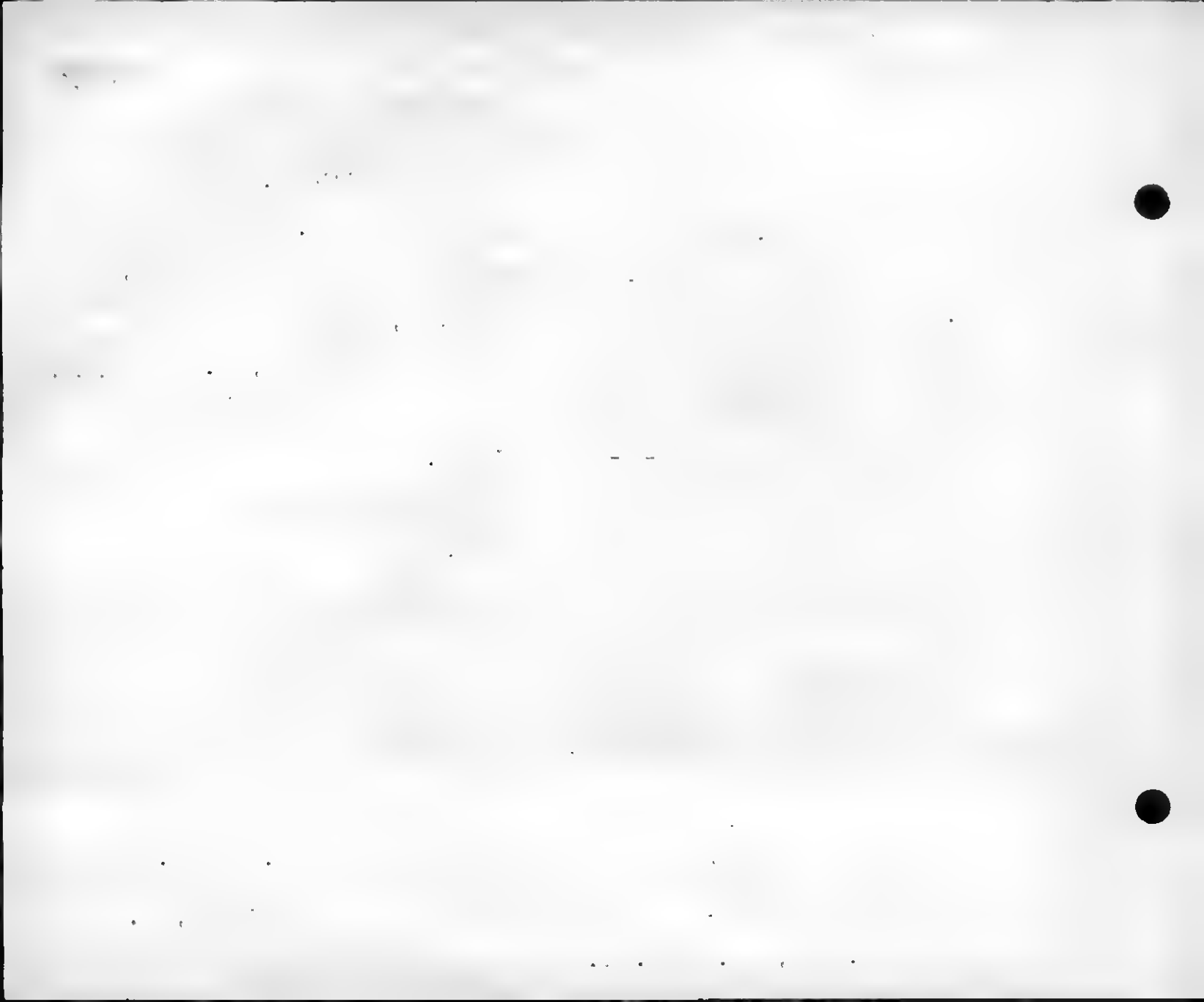
04810

04810

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. tut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8324 Beryl Rd.</b>		d. STREET ADDRESS <b>8324 Beryl Rd.</b>	
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Mansperger</b>		4 DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 67</b>	
5 SEX <b>F.M.</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 3, 1890</b>
9 AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Spielman</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Jasper</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>212-03-2535D</b>	
17 INFORMANT <b>John A. Mansperger</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Hypertensive cardiovascular Dis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b> <b>Indef.</b> <b>Indef.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 1955, to <b>18 Apr</b> , 1967, that (I) (we) last saw the deceased alive on <b>18 Apr</b> , 1967, and that death occurred at <b>10:50 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Conrad Acton</b>		22b. DATE SIGNED <b>18 Apr 67</b>	22c. PHYSICIAN'S NAME (Type) <b>Conrad Acton</b>
22d. ADDRESS <b>1208 St. Paul St.</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/22/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>APR 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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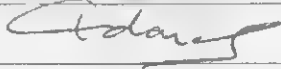
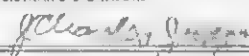


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

04811

04811

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>11 S. CAROLINE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>MANUEL</b>				4 DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>19 67</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>OCTOBER 8, 1891</b>		9 AGE (in years last birthday) <b>75</b> yrs	10 UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE, MARYLAND</b>		11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>RUFUS H. MANUEL</b>				14 MOTHER'S MAIDEN NAME <b>JENNIE JAMES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>217 05 09 39</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA WITH EMPHYSEMA</b> <del>XXXXX</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>OLD MYOCARDIAL INFARCTION</b> <del>XXXXX</del> (c) <b>RIGHT ENCEPHALOMALACIA</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 24</b> , 19 <b>67</b> , to <b>APRIL 2</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 2</b> , 19 <b>67</b> , and that death occurred at <b>115A</b> M, from causes and on the date stated above.							
22a SIGNATURE 				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <b>4/3/67</b>	
22c PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>				22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVA. (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4-6-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>Wm O. Wilson - Sr</b>		ADDRESS <b>WILSON FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>APR 6 1967</b>		25b REGISTRAR'S SIGNATURE 	
				<b>ORLEANS ST. BALTIMORE, MD.</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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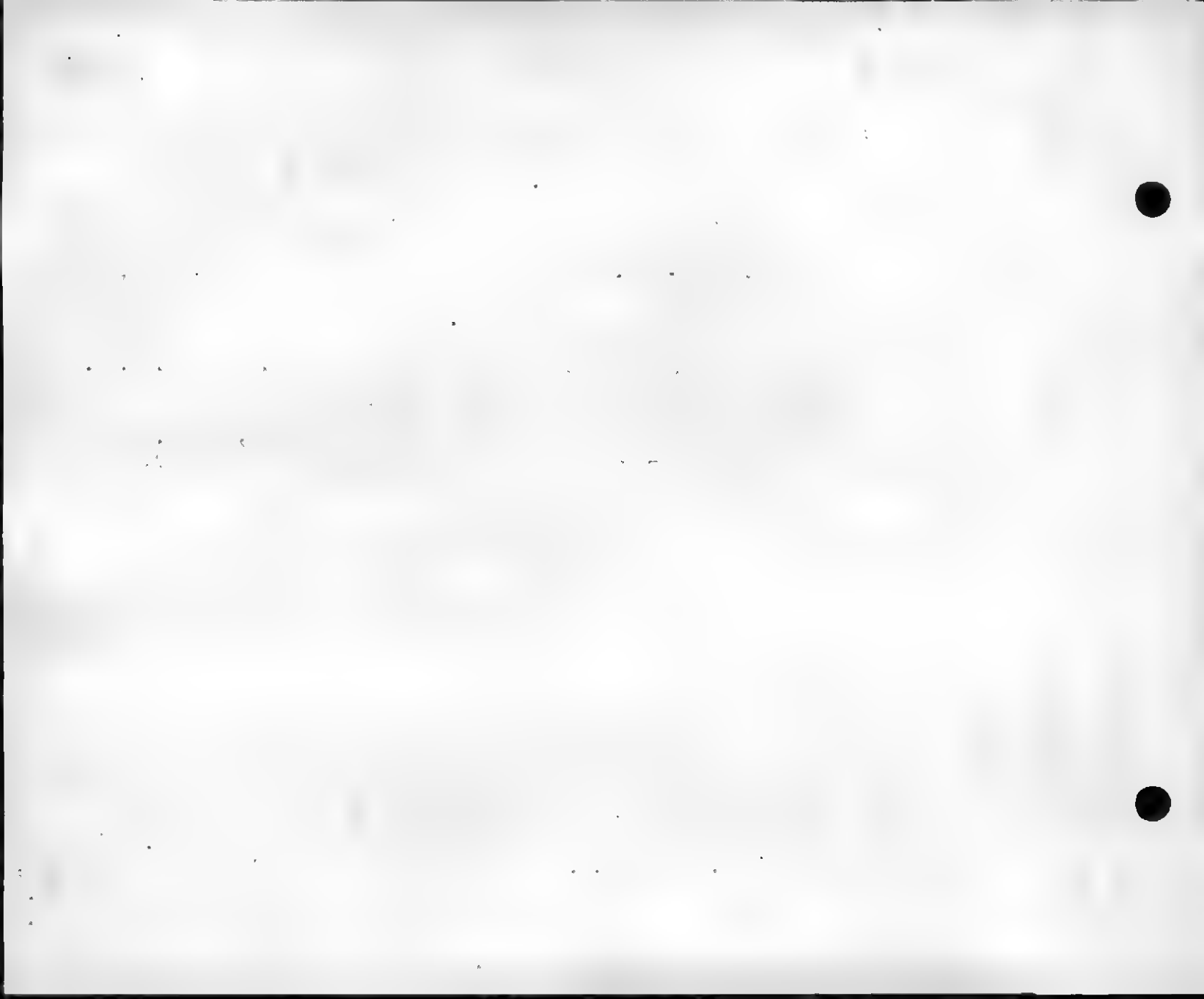
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04812

CERTIFICATE OF DEATH

04812

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>47 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount de Sales Academy</b>		e. STREET ADDRESS <b>700 Academy Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sister M. Helena Markert</b>		4. DATE OF DEATH <b>April 3, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1893</b>
9. AGE (n years last birthday) <b>73 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Adam Markert</b>		14. MOTHER'S MAIDEN NAME <b>Julia Doemling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-54-3289</b>	
17. INFORMANT <b>Sister Francis de Sales</b>		Address <b>Md. 21228</b> <b>700 Academy Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 7011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC C.V. DISEASE</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January, 1961</b> to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>11 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Dario A. Ugarte M.D.</b>		22b. DATE SIGNED <b>4/4/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dario A. Ugarte M.D.</b>		22d. ADDRESS <b>5550 Baltimore Nat'l Pike Catonsville, Md. 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/5/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount de Sales Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Catonsville Baltimore Co. Md.</b>
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>	



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

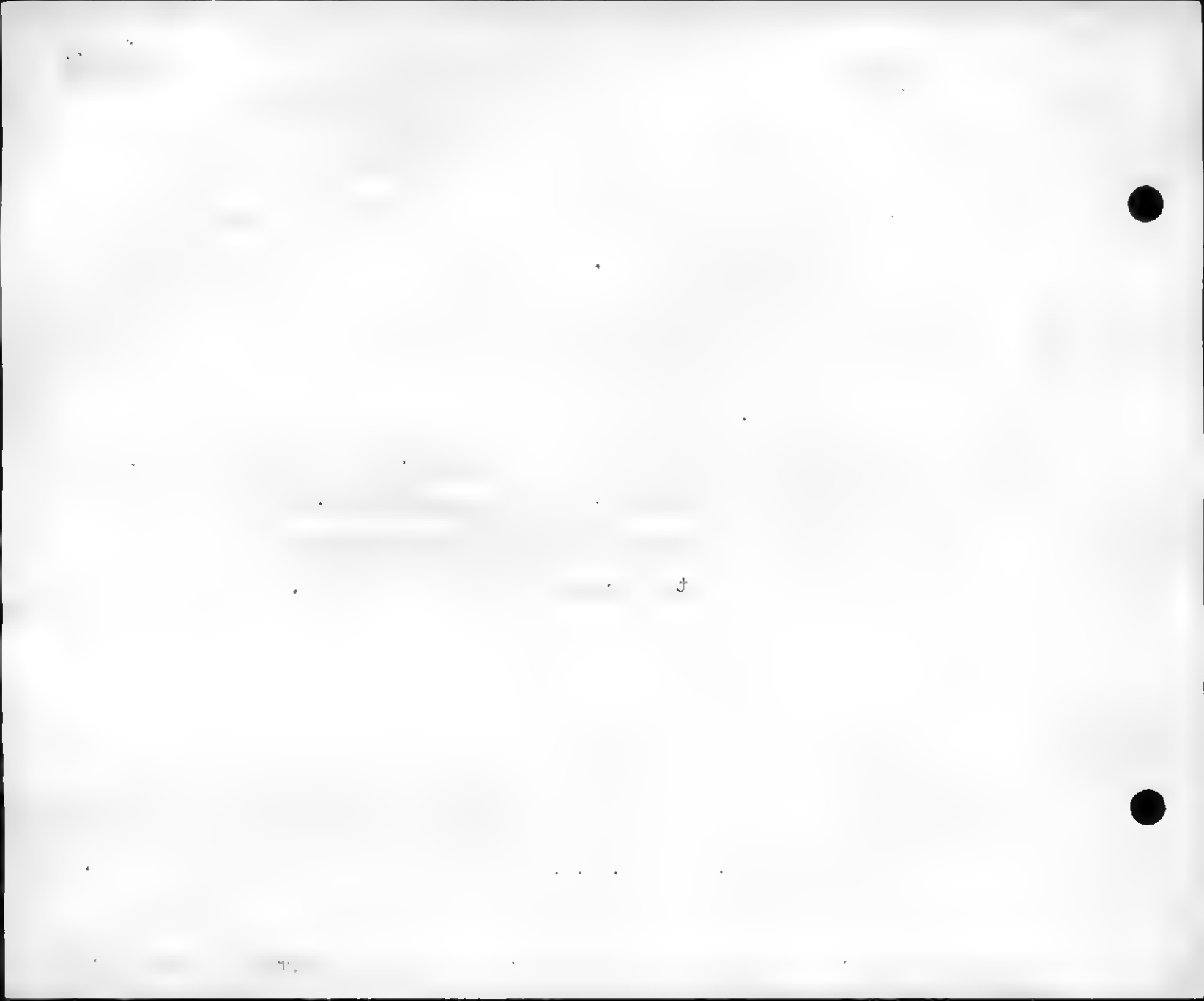
04813

04813

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1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY	
c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>1727 Gorsuch Avenue</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>V.</b> Last <b>Martin</b>		4 DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>67</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-6-94</b>
9 AGE (In years last birthday) <b>73</b>		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Brunswick, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>John A. Dorr</b>		14 MOTHER'S MAIDEN NAME <b>Alice Hartley</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>219-12-535-</b>	
17 INFORMANT <b>Robert R. Butz</b>		Address <b>5545 Gayland Rd. 21227</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Occlusion of the Right Coronary artery</b> 4/20/67 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Degenerated atherosclerotic plaque</b> DUE TO (c) <b>Atherosclerosis generalized severe.</b>			INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>April 10</b> , 19 <b>67</b> , to <b>April 23</b> , 19 <b>67</b> that (we) last saw the deceased alive on <b>April 23</b> , 19 <b>67</b> , and that death occurred at <b>3:15</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Lawrence J. Misanik, M.D.</b>		22b. DATE SIGNED <b>April 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence J. Misanik, M.D.</b>		22d. ADDRESS <b>St. Joseph Hospital Baltimore, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>4/26/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a REC'D BY REGISTRAR <b>DAK 27 1967</b>	
ADDRESS <b>4107 Wilkens Ave. 21229</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

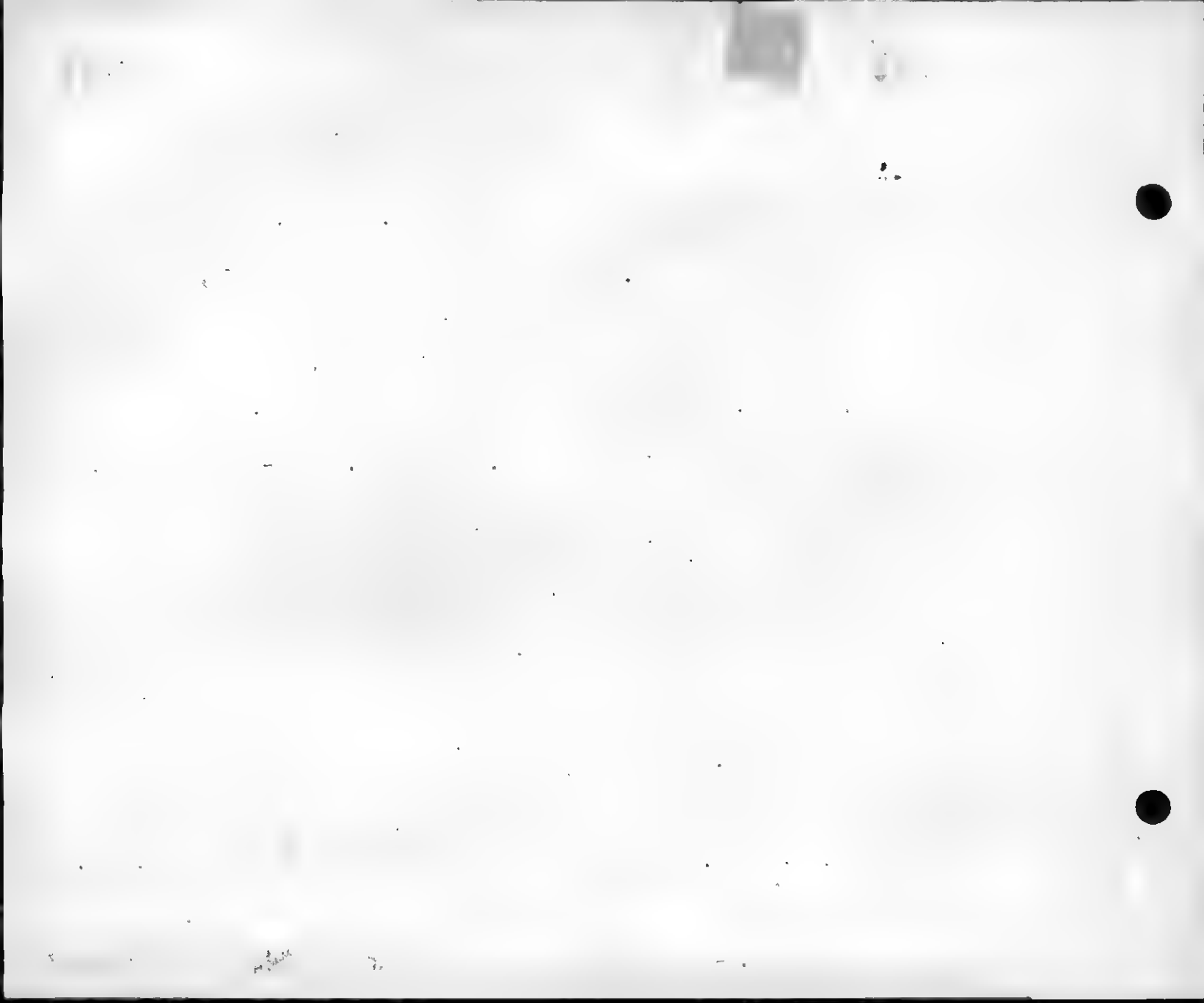
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04814

## CERTIFICATE OF DEATH

04814

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>				d. STREET ADDRESS <b>1514 E. 33rd St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>D.</b> Last <b>MASSEY</b>				4. DATE OF DEATH <b>April 25, 1967</b> Month Day Year			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1882</b>	9. AGE (In years last birthday) <b>84</b> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dr. Edwin G. Darling</b>				14. MOTHER'S MAIDEN NAME <b>Anna M. Brendel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-03-1260</b>		17. INFORMANT Address <b>Mrs. Florence M. Black- 1 W. University Pkwy</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arteriosclerotic Hypertension</b> <b>Heart Disease - Congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>stroke pneumonia</b> (c) <b>myocardial infarction</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>fracture of left femur operated 10/25/66</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>fracture sustained after fall down steps</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>May 14, 1966</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1966</b> to <b>April 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 24, 1967</b> , and that death occurred at <b>1:55 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Donald W. Mintzer</b>				22b. DATE SIGNED <b>4/26/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mintzer</b>	
22d. ADDRESS <b>3009 Evergreen Ave., Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>entombment</b>		23b. DATE THEREOF <b>4/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. - Baltimore, Md. -- 14</b>				25a. REC'D BY REGISTRAR DATE <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

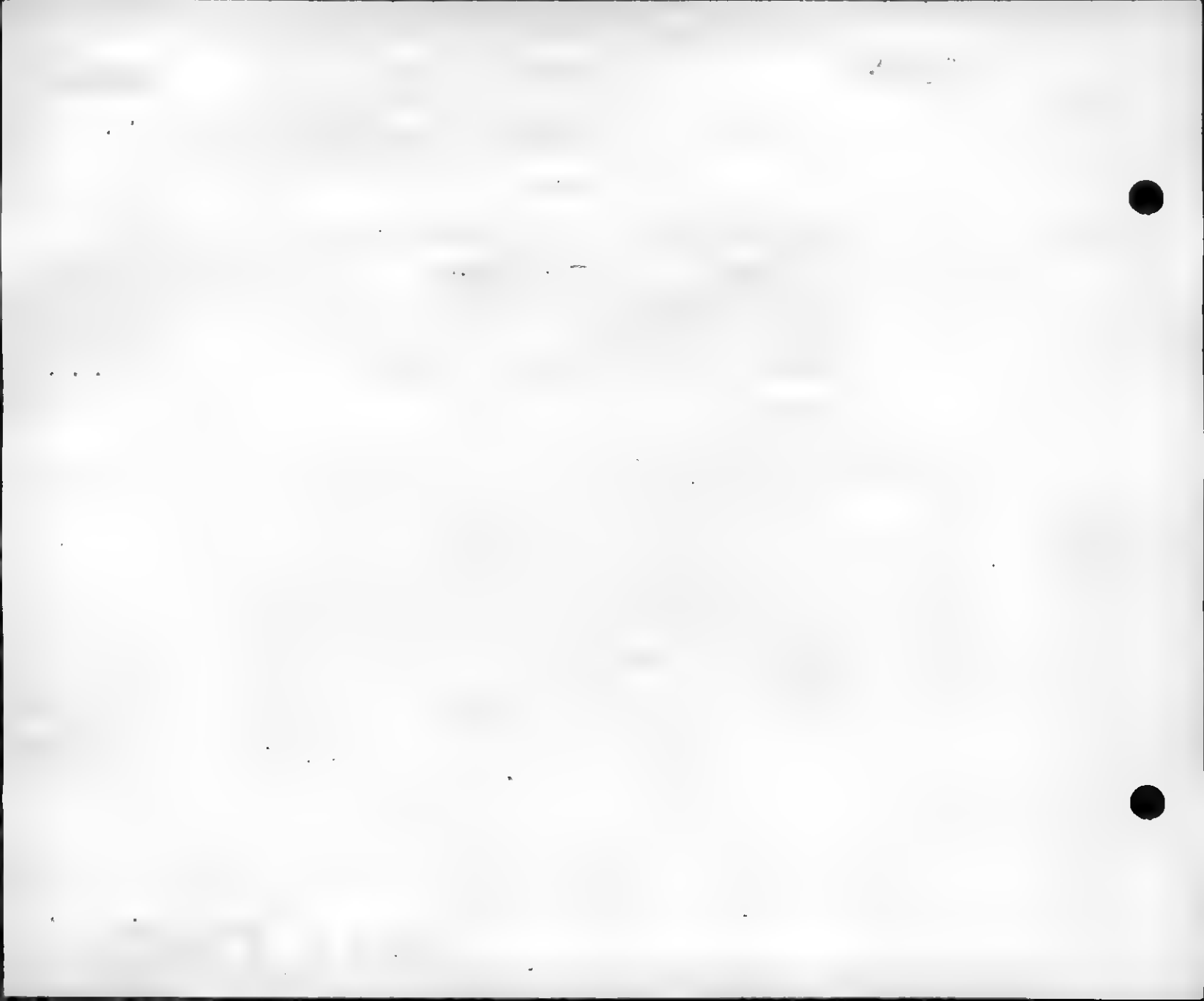
04815

**CERTIFICATE OF DEATH**

04815

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>			c. LENGTH OF STAY IN 1b <b>14yrs</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8902 Belair Road</b>				d STREET ADDRESS <b>8902 Belair Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>MATTHEW</b> Last <b>MURPHY</b>				4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>1967</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-22-1878</b>	
9. AGE (In years last birthday) <b>88 yrs</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Show business</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Shpw girl</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore City</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13 FATHER'S NAME <b>Unknown</b>			
14 MOTHER'S MAIDEN NAME <b>Unknown</b>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>216-10-4267D</b>		17. INFORMANT Address <b>Mrs Mary Moore 8902 Belair Road 36</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Coronary failure grade IV</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>gent arteriosclerosis</b> (c) <b>gent arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1956</b> to <b>April 8, 1967</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Mar 15, 1967</b> , and that death occurred <b>4:00 A.M.</b> from causes and on the date stated above.							
22a SIGNATURE <b>Donald M. Minter</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/10/67</b>	
22c. PHYSICIAN'S NAME (Type)				22d ADDRESS <b>3009 EVERGREEN AVE BALTO</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>	
24 FUNERAL DIRECTOR <b>Lassahn Funeral Home 7411 Belair Road</b>				25a REC'D BY REGISTRAR <b>APR 11 1967</b>			
				25b REGISTRAR'S SIGNATURE <b>John Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04816

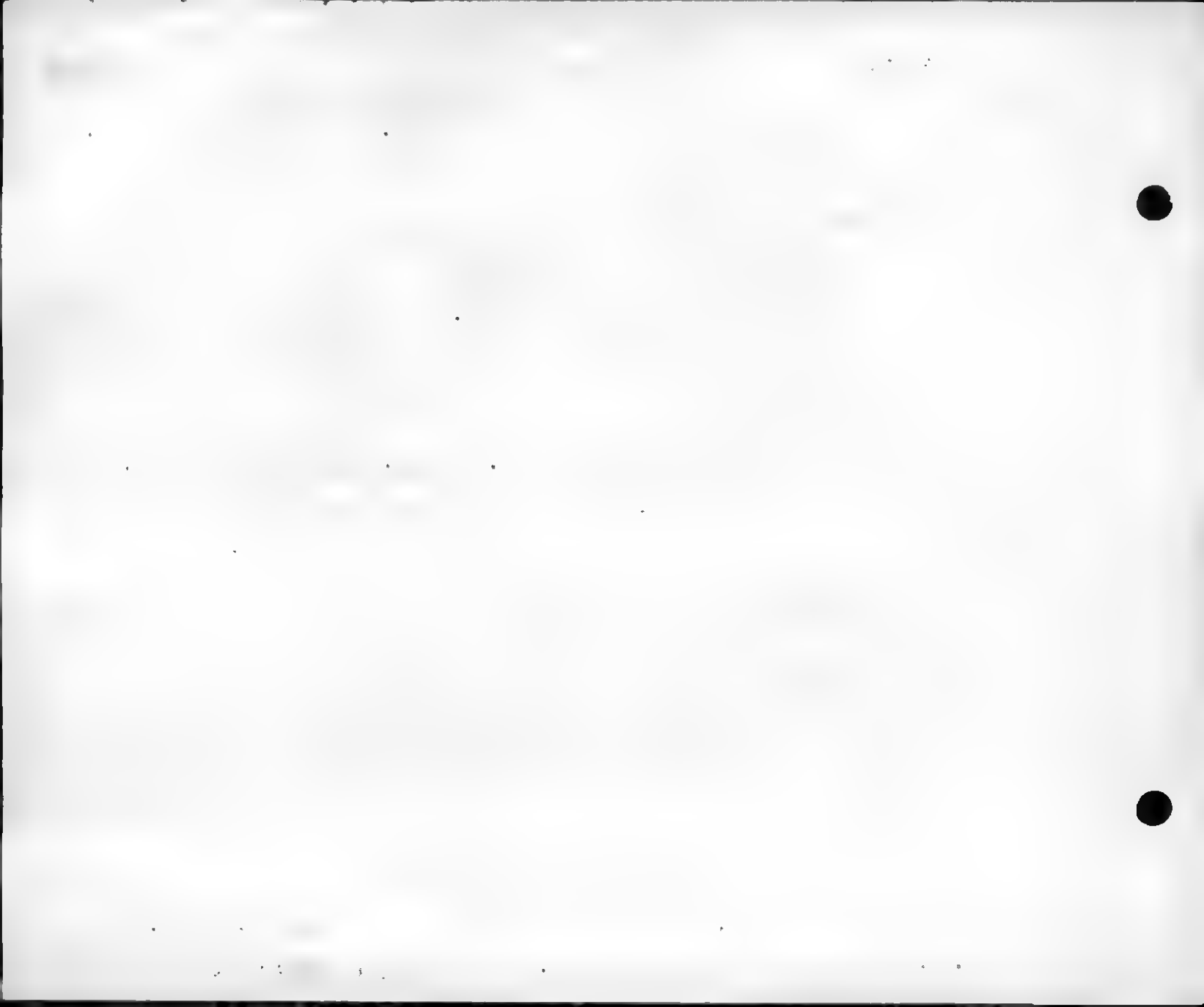
## CERTIFICATE OF DEATH

04816

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY N 1b <i>Owings Mills</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1 Samuel Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Annie</i> First Middle Last <i>Maxwell</i>		4 DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 19, 1878</i>
9. AGE (In years, best birthday) <i>87</i> yrs		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>21</i> Hours <i>1</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wisconsin</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Daved Woodruff</i>		14. MOTHER'S MAIDEN NAME <i>Mary Roach</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-48-2161</i>	
17. INFORMANT <i>Mrs. Leona M. Lloyd</i>		Address <i>Owings Mills, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i> 101X DUE TO <i>Metastases to liver &amp; lungs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cachexia</i> (c) <i>1 yr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-1-1932 to 4-7-1967</i> that (I) (we) last saw the deceased alive on <i>4-6-1967</i> and that death occurred at <i>2:45</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>James B. Saffell</i>		22b. DATE SIGNED <i>4-8-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>James B. Saffell MD</i>		22d. ADDRESS <i>Reisterstown</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 10, 67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Md.</i>	
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>APR 10 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

04817

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04817

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>			
c. LENGTH OF STAY IN 1b <u>60 yrs.</u>				d. STREET ADDRESS <u>Mt. Carmel Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mt. Carmel Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER GILBERT MAYS</u>				4. DATE OF DEATH <u>APR 18 1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22, 1906</u> 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Mays</u>				14. MOTHER'S MAIDEN NAME <u>Florence Bull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>166-12-4397</u>		17. INFORMANT <u>Mrs. E. Pearl Mays, Parkton, Md. 21120.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>G. M. France</u>				22. DATE SIGNED <u>4/18/67</u>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>April 21, 1967</u>		<u>Mt. Carmel Cemetery</u>		<u>Parkton, Md.</u>	
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				<u>APR 21 1967</u>			

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04818

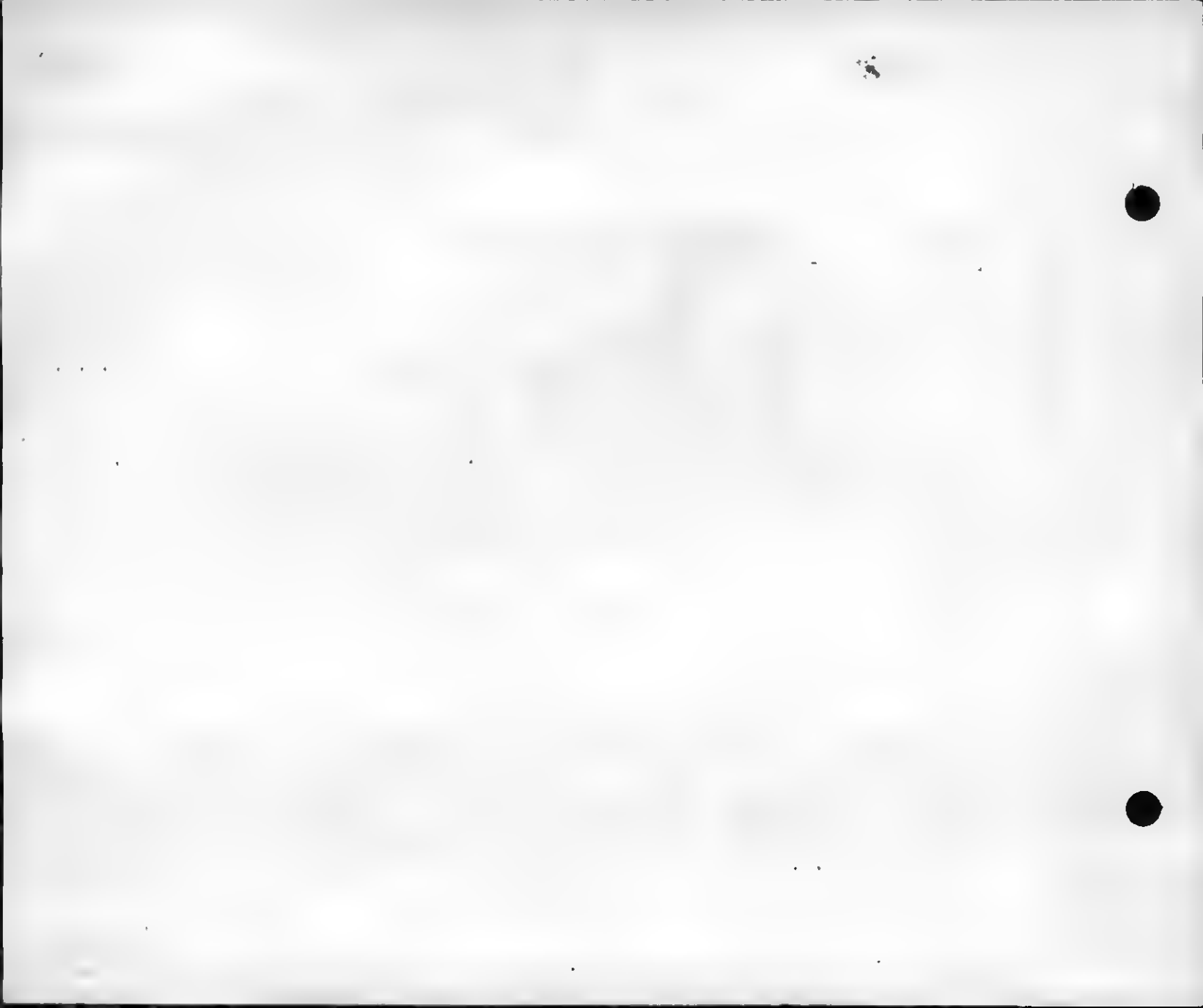
CERTIFICATE OF DEATH

04818

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>xxxxxxx Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c LENGTH OF STAY IN 1b <b>xxxxxxx</b> <b>Glenburnie</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summitt Nursing Home</b>		d STREET ADDRESS <b>10 Greenwood Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>MATHILDA MAZZA</b>		4 DATE OF DEATH <b>April 19, 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/14/69</b>
9 AGE (In years last birthday) <b>98</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	11 IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Italy</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Christopher Mazza</b>	
14 MOTHER'S MAIDEN NAME <b>Louisa Puzza</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT Address <b>Mrs. Jean Shea 10 Greenwood Ave.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Chronic Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>Coronary and Arteriosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 years</b> <b>15 years</b> <b>10 years</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <b>9/5/62</b> to <b>4/19/67</b> , that (i) (we) last saw the deceased alive on <b>4/18/67</b> 19 <b>67</b> , and that death occurred at <b>755A</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>W.E. McGrath</b>		22b DATE SIGNED <b>4/20/67</b>	
22c PHYSICIAN'S NAME (Type) <b>W.E. McGrath</b>		22d ADDRESS <b>1303 Frederick Rd. 28/mc</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/22/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		25a REC'D BY REGISTRAR <b>APR 21 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove cordon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

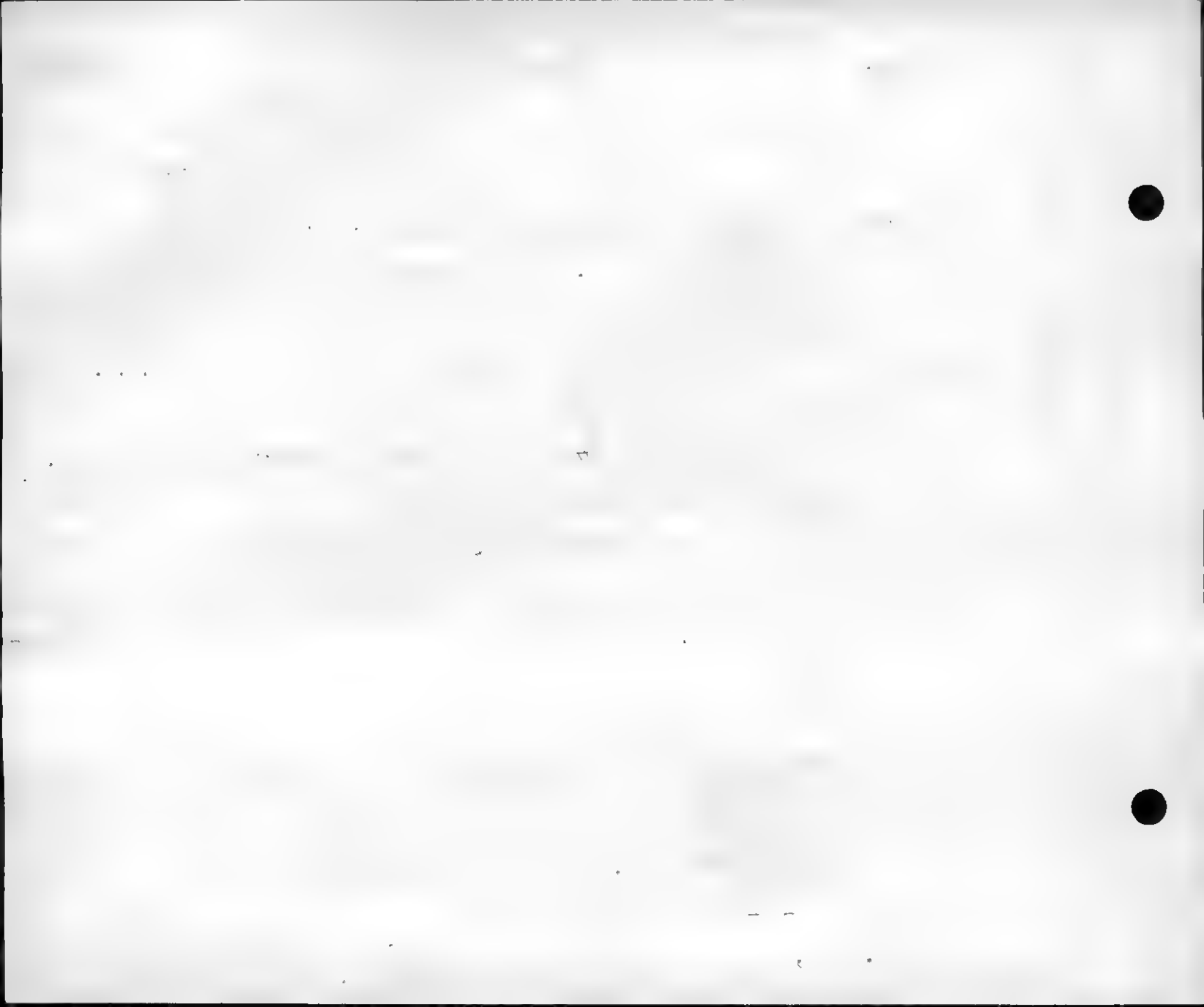
04819

CERTIFICATE OF DEATH

04819

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE (Jones Creek)</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>7350 GEISE AVENUE 21219</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>MC CLELLAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 21, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>PIPE MILL</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>BENWOOD, WEST VIRGINIA</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>JOHN MC CLELLAN</b>		15. MOTHER'S MAIDEN NAME <b>MARGARET HADDOX</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		17. SOCIAL SECURITY NO <b>213 07 47 32</b>	
18. INFORMANT <b>CLIN RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>PULMONARY INFARCTION. LOBAR PNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>14 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	21d. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>3/31/67</b> , 19__, to <b>4/12/67</b> , 19__, that (I) (we) lost saw the deceased alive on <b>4/12/67</b> , 19__, and that death occurred at <b>3:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>George Dudas</b>		22b. DATE SIGNED <b>4/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-15-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEMETERY</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>John J. Duda,</b>		25a. REC'D BY REGISTRAR <b>APR 14 1967</b>	
ADDRESS <b>DUDA FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
<b>WISE AVENUE, BALTIMORE, MD.</b>			

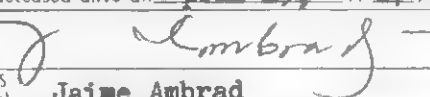



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04820

CERTIFICATE OF DEATH

04820

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN IT d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21206</b> d. STREET ADDRESS <b>7200 Willowdale Ave. 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Aubrey</b> Middle <b>Vance</b> Last <b>McCLINTOCK</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>19</b> Year <b>19 67</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August 14, 1914</b>		<b>9. AGE</b> (In years last birthday) <b>52 yrs</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Welding Inspector</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Beth. Steel</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>George W. McClintock</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>Minnie Heath</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				
<b>16. SOCIAL SECURITY NO.</b> <b>239-09-2959</b>			<b>17. INFORMANT</b> <b>Mrs Ann M. McClintock</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Colonic Ca with widespread Metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <b>March 31, 19 67</b> , to <b>April 19, 1967</b> , that <b>(we)</b> last saw the deceased alive on <b>April 19, 19 67</b> , and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.							
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Jaime Ambrad</b>				<b>22b. DATE SIGNED</b> <b>April 19 1967</b>			
<b>22d. ADDRESS</b> <b>7620 York Rd., Towson, Md. 21204</b>				<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4-22-1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Montlawn Cemetery</b>			
<b>23d. LOCATION (City or Town)</b> <b>Raleigh N. Carolina</b>		<b>(County)</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Lussahan F. Home 741 Belair Rd</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 24 1967</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

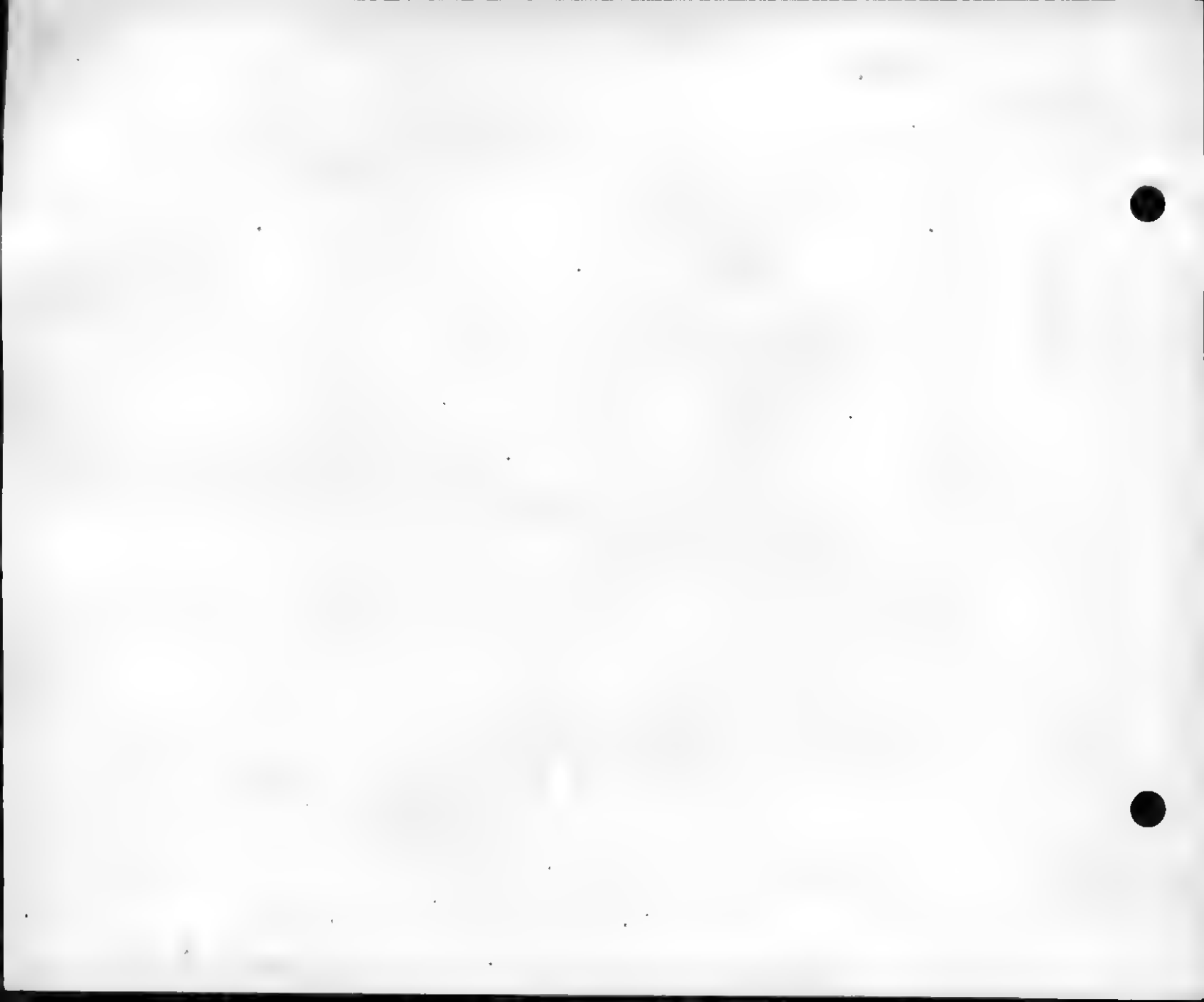
04821

04821

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN It <b>21229</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21229</b> d. STREET ADDRESS <b>907 Beechfield Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>M.</b> Last <b>McLAUGHLIN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1894</b>
9. AGE (In years lost birthday) <b>72</b> yrs		10. FUNDING YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min <b>72</b>	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph G. McLaughlin</b>		14. MOTHER'S MAIDEN NAME <b>Marie Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>215-18-5454</b>		16. SOCIAL SECURITY NO <b>215-18-5454</b>	
17. INFORMANT <b>M. Magdalen McLaughlin</b>		Address <b>21229 907 Beechfield Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suppurative bronchopneumonia involving left lower lobe.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Post-operative left upper lobectomy.</b> (c) <b>Adenocarcinoma, left upper lobe.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>A</b> (this hospital) attended the deceased from <b>April 1, 1967</b> , to <b>April 25, 1967</b> , that <b>A</b> (we) last saw the deceased alive on <b>April 25, 1967</b> , and that death occurred at <b>10:25M</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		22b. DATE SIGNED <b>April 25, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/29/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Queenstown, Md. St. Peter's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Queenstown Md.</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>21229</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>Apr 28 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

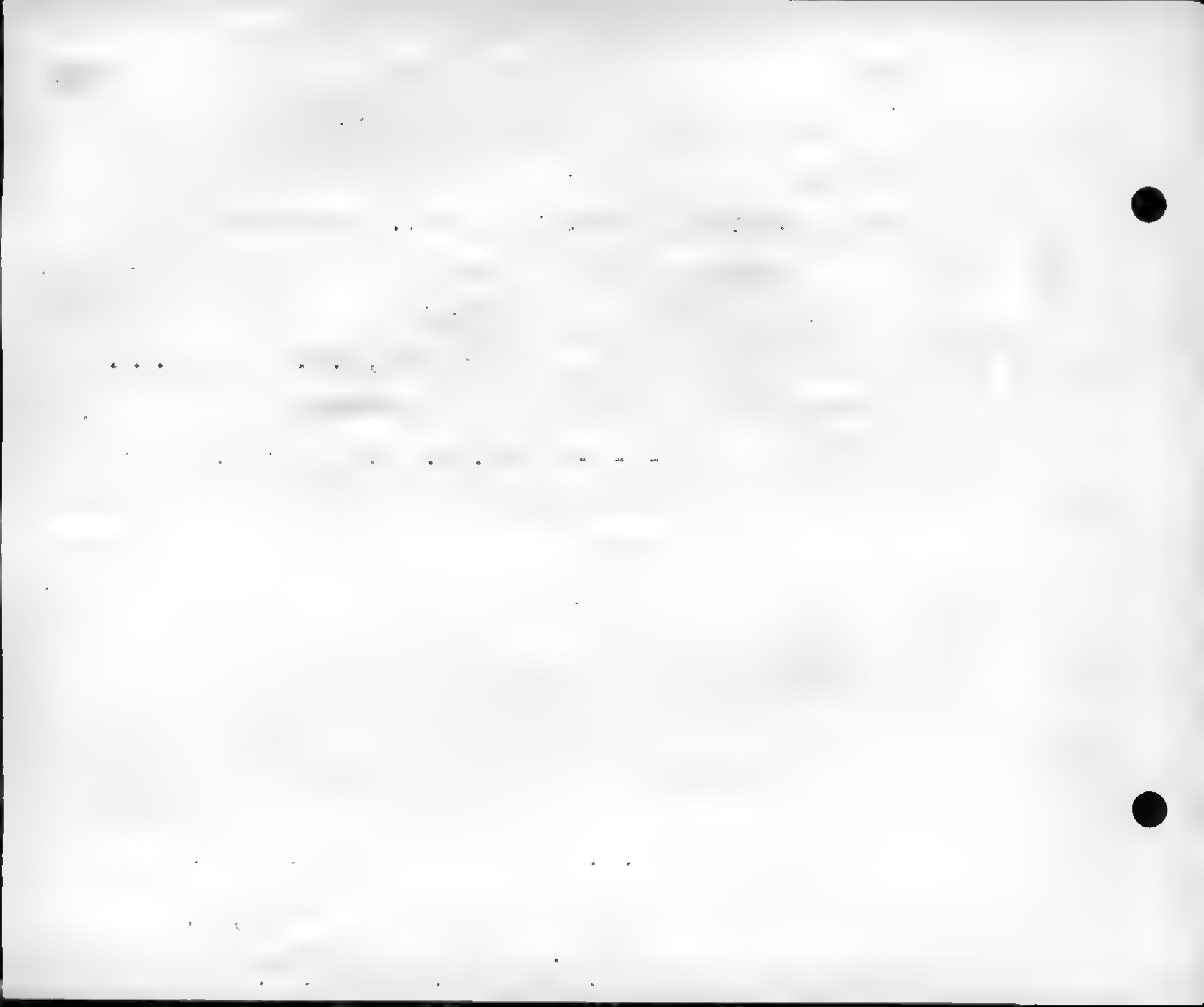
04822

CERTIFICATE OF DEATH

04822

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>401 N. Curley Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MANUEL LUTHER MC NEILL</b>				4. DATE OF DEATH Month Day Year <b>APRIL 16 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/18</b>	9. AGE (in years last birthday) yrs <b>48</b>	10. FUNERAL 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Marlinton, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Arnot Mc Neill</b>				14. MOTHER'S MAIDEN NAME <b>Ida Beverage</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>			16. SOCIAL SECURITY NO <b>232-22-54-69</b>	17. INFORMANT Address <b>Clin. Rec. VAH, Fort Howard, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <del>XXXXXX</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause was } (b) <b>HEPATIC COMA</b> DUE TO (c) <b>PORTAL CIRRHOSIS OF LIVER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 11, 1967</b> to <b>April 16, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 16, 1967</b> , and that death occurred at <b>7:35 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Raul de Castro</i>				22b. DATE SIGNED <b>4/17/67</b>		22c. PHYSICIAN'S NAME (Type) <b>RAUL DE CASTRO, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>4/21/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAMPTON, VA.</b>	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino Jr.</i>				25a. REC'D BY REGISTRAR <b>JOSEPH N. ZANNINO FUNERAL HOMES</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <b>APR 18 1967</b>			
257 S. CONKLING ST. BALTIMORE, MD.							

MEDICAL CERTIFICATE ON





TO HOSPITAL OR ATTENDING PHYSICIAN: The ☒ requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A.5 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04823		04823									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>GREATER BALTO. MEDICAL CENTER</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>51 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER</b> <b>6301 N. CHARLES ST.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b> d. STREET ADDRESS <b>RT. 16, BOX 163 A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HARRY ALFRED MENTZER</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>19</b> Year <b>1967</b>			5. SEX <b>MALE</b>			6. COLOR OR RACE <b>CAUCASIAN</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <b>12-5-08</b>			9. AGE (In years last birthday) <b>58</b> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRYER OPERATOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>LEVER BROS. CO</b>			11. BIRTHPLACE (County & State, or foreign country) <b>ALTOONA, PENN.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>HARRY THOMAS MENTZER</b>			14. MOTHER'S MAIDEN NAME <b>MAGGIE M. YOUNG</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>170-12-1288</b>			17. INFORMANT <b>Ethel Menyzer Box 163A Bird River Rd. 20</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca Lung</b> <b>10. X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>—</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2-26 - 1967</b> , to <b>4-19 - 1967</b> , that (I) (we) last saw the deceased alive on <b>4-19 - 1967</b> , and that death occurred at <b>10:55 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>RCHILLAR</b>						22b. DATE SIGNED <b>4-19-67</b>					
22c. PHYSICIAN'S NAME (Type) <b>RAM K. CHILLAR</b>						22d. ADDRESS <b>GRTR BALTO MED. CENTER</b> <b>BALTIMORE, MD. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/22/67</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home 1407 Eastern Ave.</b>						25a. REC'D BY REGISTRAR <b>APR 24 1967</b>			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		

MEDICAL CERTIFICATION

20 11-11 20 - 11-11

20 - 11-11

X

20 - 11-11

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

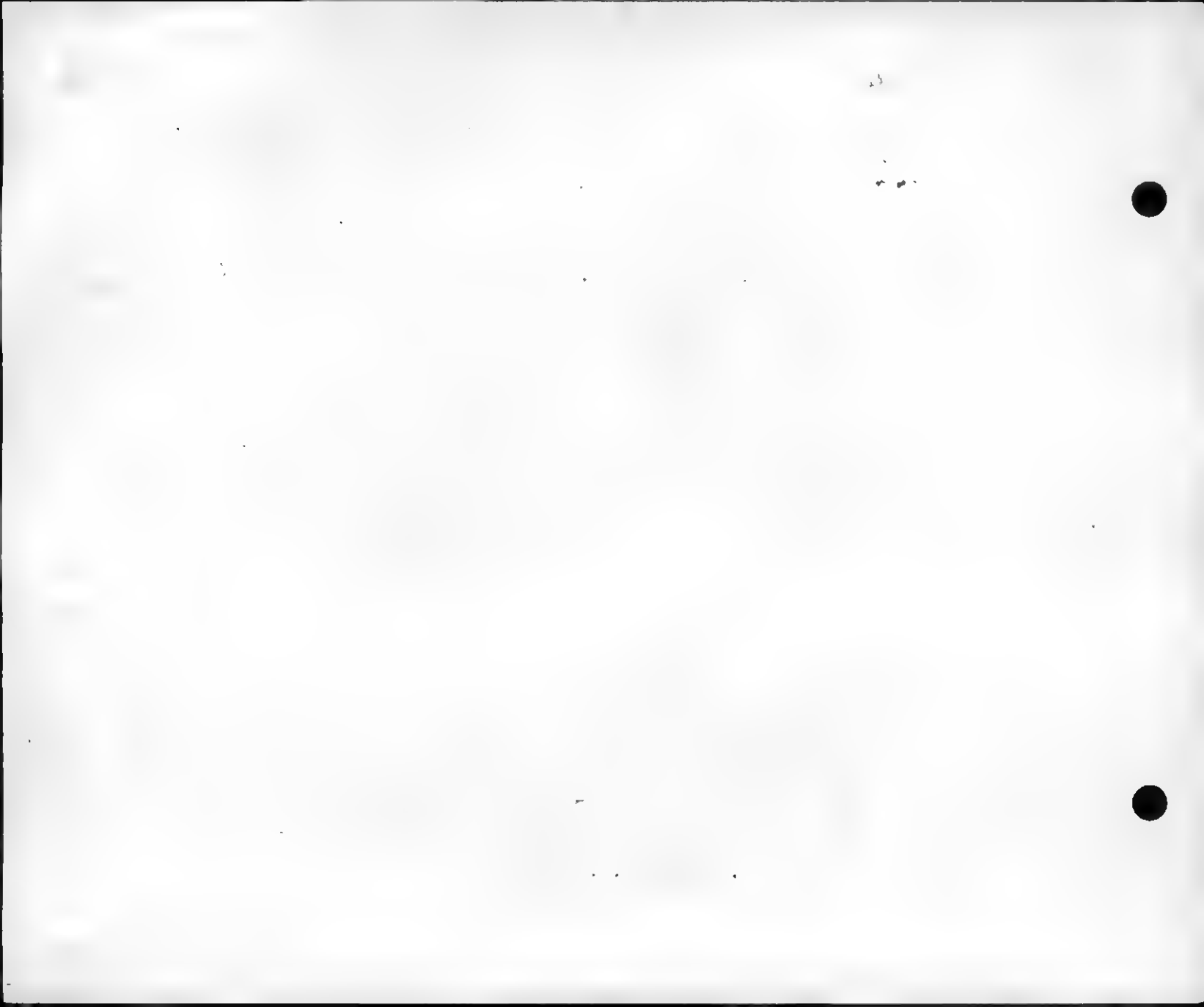
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04824

04824

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Long Green</b>				c. LENGTH OF STAY IN lb <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hyde Road - Long Green Pike</b>				d. STREET ADDRESS <b>Glen Arm Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last <b>ELMER R. MILLER</b>				4 DATE OF DEATH Month Day Year <b>4 4 1967</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8/29/23</b>		9 AGE (In years, last birthday) yrs <b>43 ?</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mother's Helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11 BIRTHPLACE (State or foreign country) <b>Ind.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13 FATHER'S NAME <b>Leroy Miller</b>				14 MOTHER'S MAIDEN NAME <b>Mary Hall</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>				16 SOCIAL SECURITY NO <b>218 14-7280</b>		17 INFORMANT Address <b>Edna Ralston, 214 W. 11th St.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 'a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8) <b>Unknown - Found in creek</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>4 4 1967</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Creek</b>	
20f. (City or town, County, State) <b>Baltimore Md.</b>							
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				22. DATE SIGNED <b>4-4-67</b>			
EXAMINER'S NAME (Type)				Address (Street, city, town or county)			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West View</b>		23d. LOCATION (City or Town, County, State) <b>West View, Balto. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. E. Whitman - 1701 N. Charles St.</b>				25a. REC'D BY REGISTRAR <b>APR 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15 also listed



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

M

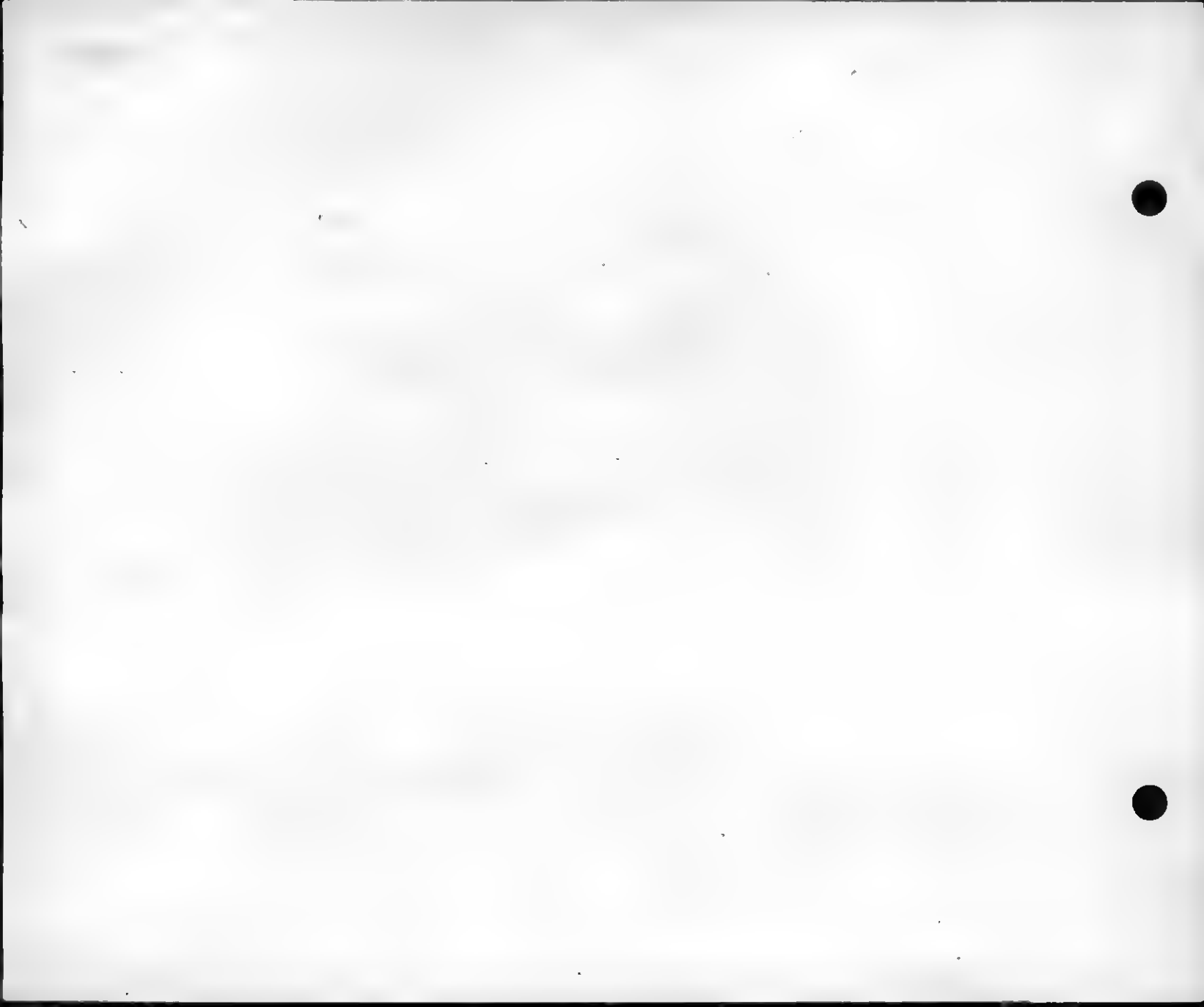
Items 18-21 Film 387 4-1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04825

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04825

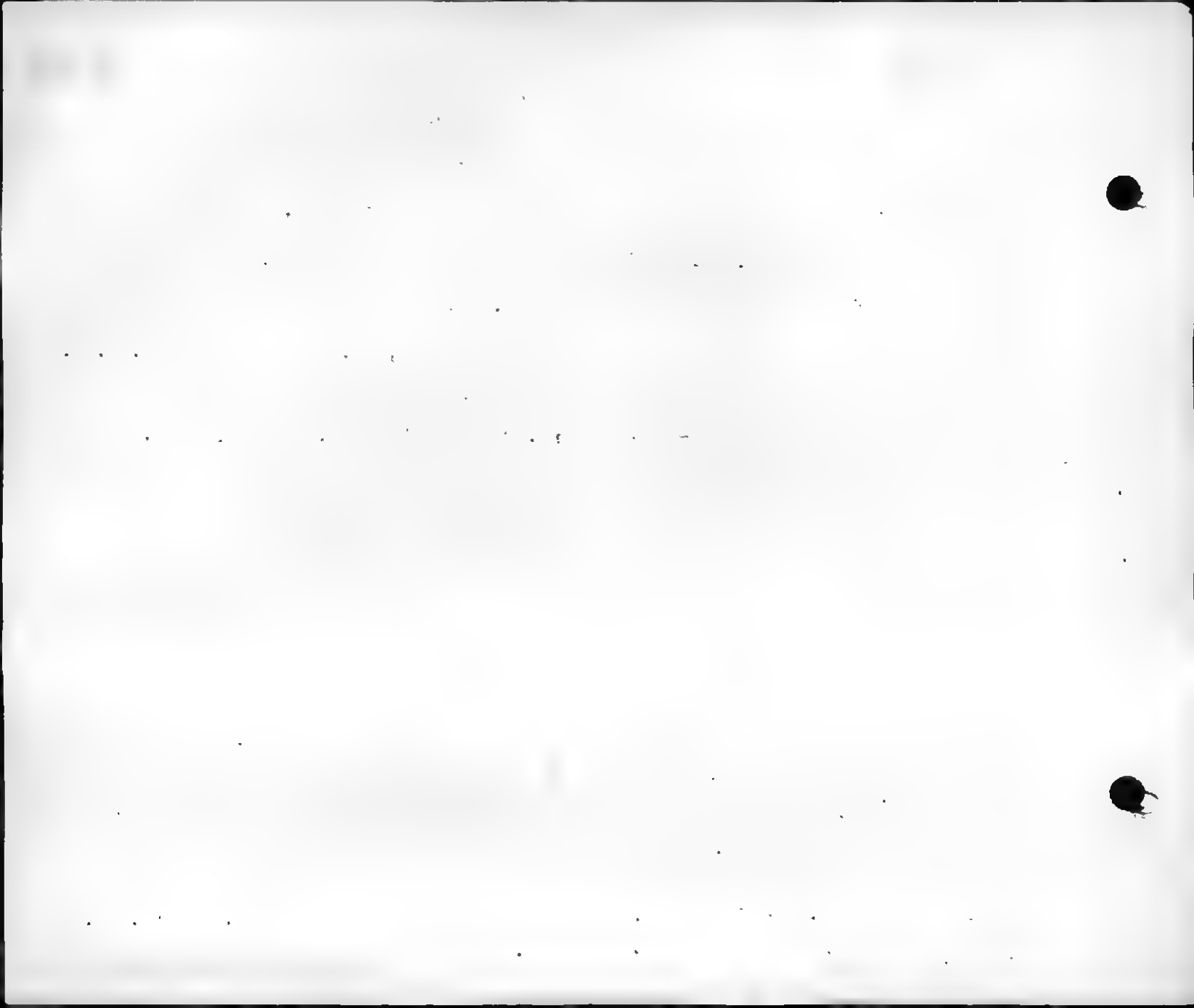
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c LENGTH OF STAY in days <b>years</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>820 Scarlett Drive</b>				e STREET ADDRESS <b>820 Scarlett Drive</b>			
3 NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Wilbur</b> Last <b>MILLER</b>				4 DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 1, 1886</b>		9 AGE (In years last birthday) <b>80</b> yrs	10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Food Supply</b>		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Daniel Jacob Miller</b>				14 MOTHER'S MAIDEN NAME <b>L. Ellen Ernest</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>220-18-4169</b>		17 INFORMANT Address <b>Mrs. Esther Miller, Same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury to chest and abdomen</b> <b>8359</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Car fell off jack</b>					
20c TIME OF INJURY Month, Day, Year Hour <b>4:00</b> p.m. <b>4 8 1967</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Towson Balto Md</b>	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MED. CA. EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22 DATE SIGNED <b>4/9/67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Apr. 11, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>				25a REC'D BY REGISTRAR <b>APR 12 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item #2c & d Film 37-11-106-67 pc									
04826									
CERTIFICATE OF DEATH									
Reg. Dist. No. 04826									
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VILLE 2.228</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21225</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>					d. STREET ADDRESS <u>407 Arsan Ave</u> <u>5743 Campbell Ave.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY KATHERINE MILLER</u>					4. DATE OF DEATH Month Day Year <u>April 16 19 67</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1881</u>		9. AGE (In years lost birthday) <u>85</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James Turner</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Nash</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, no, or unknown</u>					16. SOCIAL SECURITY NO <u>215-52-0067</u>				
17. INFORMANT <u>Mrs. Margaret Hoffman</u>					Address <u>407 Arsan Ave. 21225</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>January 1967</u> to <u>April 16, 1967</u> , that I last saw the deceased alive on <u>April 10, 1967</u> and that death occurred at <u>90</u> M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>1725 S. D. St. Baltimore, Md.</u>									
DATE SIGNED <u>4/17/67</u>									
ACTUAL SIGNATURE <u>Richardo Cruzada</u> M.D.									
PHYSICIAN'S NAME (Type) <u>RICHARDO CRUZADA M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>Apr. 19-67</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>									
22d. LOCATION (City, town, or county) (State) <u>Frederick Ave., Balto. Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Flora C. Fleming</u>									
ADDRESS <u>1422 Light St.</u>									
24a. REC'D BY REGISTRAR <u>APR 19 1967</u>									
24b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>									





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

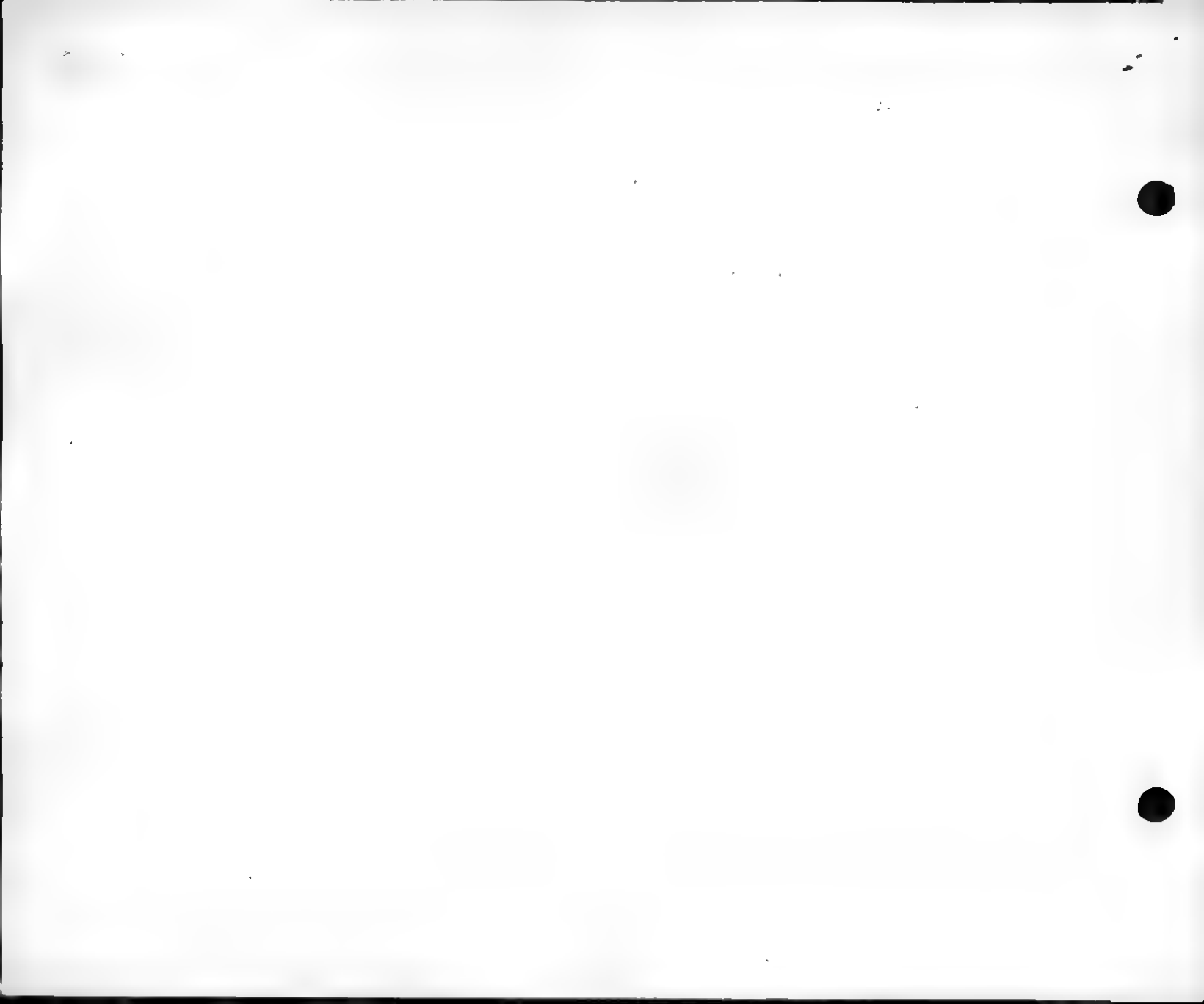
VR A15ME (5)  
6M 1/66

04827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04827

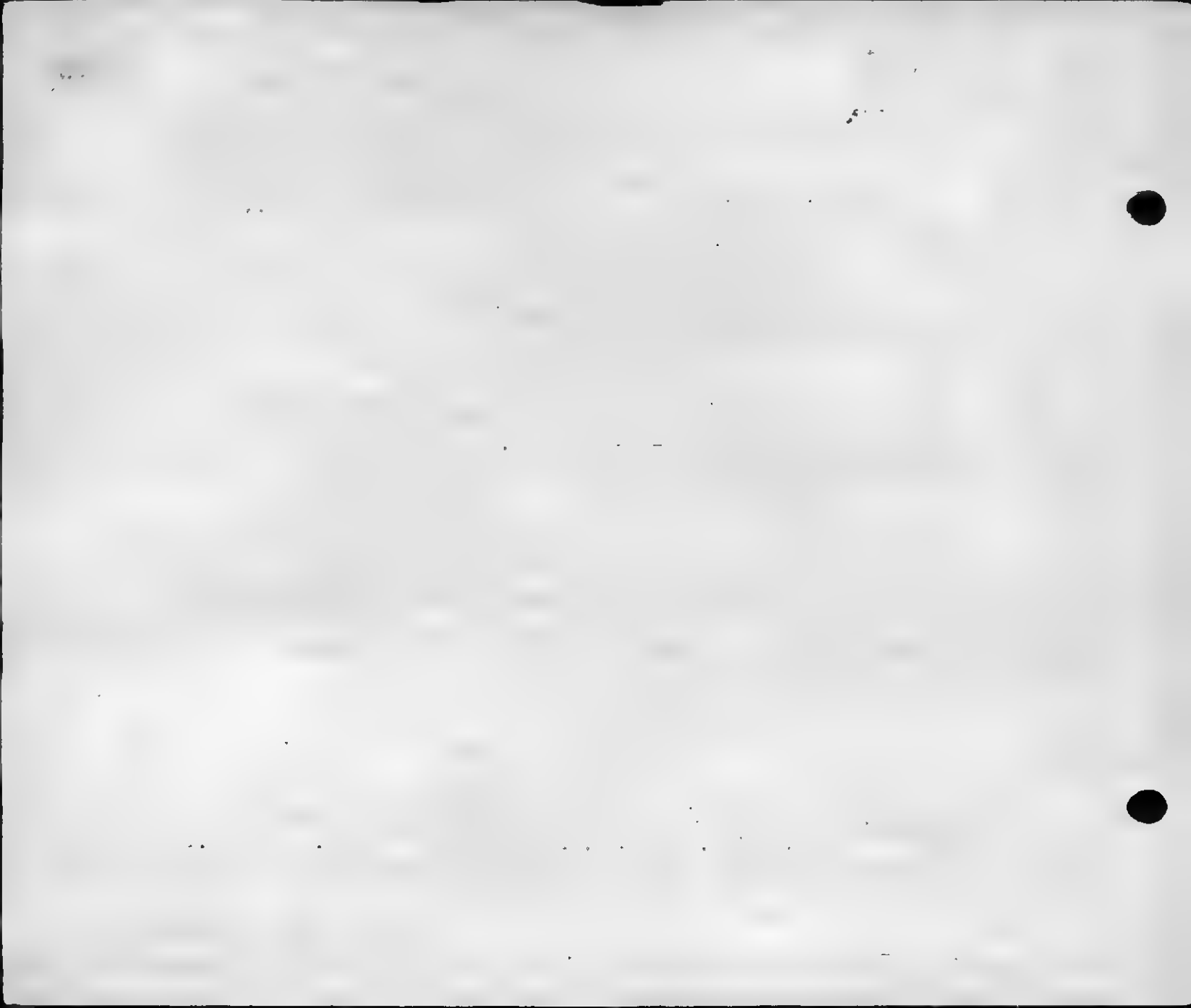
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore-8</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-8</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Balto. Co. General Hosp.</b>		d. STREET ADDRESS <b>609 Leafydale Terrace</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Morris</b> Middle <b>B.</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1929</b>
9. AGE (In years last birthday) <b>37</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Claims examiner</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Soc. Sec.</b>	
13. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Isadore Miller</b>		16. MOTHER'S MAIDEN NAME <b>Mildred Mitnick</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO <b>212-26-2096</b>	
19. INFORMANT <b>Mrs. Sue Ellen Miller, 609 Leafydale Terrace,</b>		Address <b>Balto. 8, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min. est.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.		22. DATE SIGNED <b>4-3-67</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		6 Hanover Road, <b>Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-3-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Brown, Inc., 6010 Reist. Rd., Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b. <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7003 Eastern Ave.,</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>Flora Miner</u> First <u>M</u> Middle Last					<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>13</u> Year <u>1967</u>						
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/15/1891</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hswf</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>a t home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>William Wilkens</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Hachtel</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214-12-8695D</u>		<b>17. INFORMANT</b> <u>Mr. Roland Miner</u> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Emboli</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Aseptic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/13/62</u> <b>to</b> <u>4/13</u> <b>19</b> <b>67</b> <b>that (I) (we) last saw the deceased alive on</b> <u>4/12</u> <b>19</b> <b>67</b> <b>and that death occurred at</b> <u>6:30</u> <b>AM</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Robert J. Mahon</u>				<b>22b. ADDRESS</b> <u>204 E. Joppa Rd.,</u>		<b>22c. DATE SIGNED</b> <u>4/13/67</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert J. Mahon, M.D.</u>				<b>22d. ADDRESS</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/15/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Maryland</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>				<b>25. REG'D BY REGISTRAR</b> <u>APR 17 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

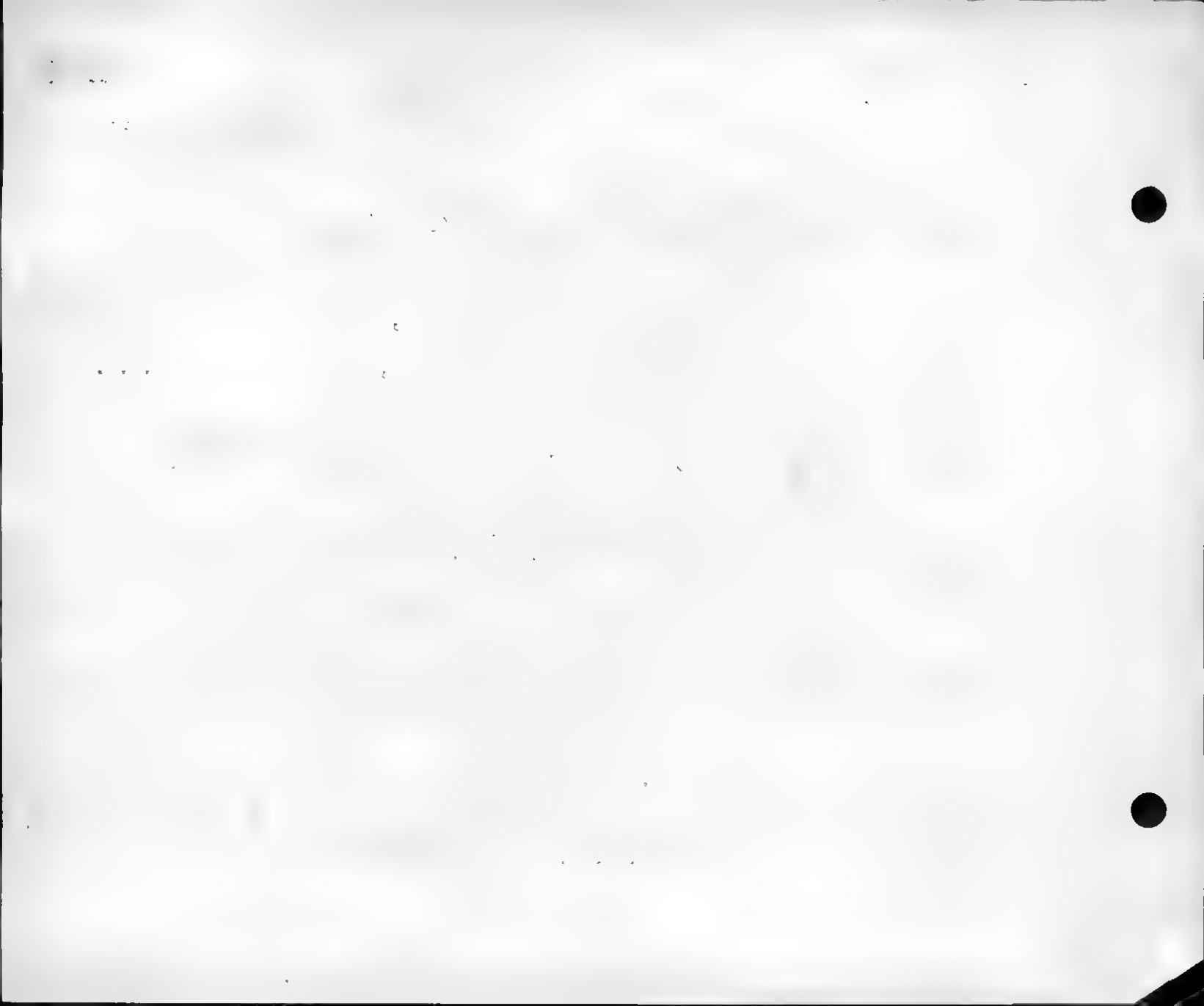
04829

04829

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>14 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1213 KIMBERLY LANE</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>BERNARD</b> Last <b>MONSEN</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JANUARY 6, 1891</b>
9 AGE (In years last birthday) <b>76</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRICK LAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>CHICAGO, ILLINOIS</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>MORRIS MONSEN</b>		14 MOTHER'S MAIDEN NAME <b>ANNA ANDERSON</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>319 09 45 01</b>	
17 INFORMANT <b>VA HOSPITAL</b>		18 CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> XIM <b>BRONCHOGENIC CARCINOMA RIGHT</b> XIM <b>METASTATIC CARCINOMA, RIBS, STERNUM AND CHEST WALL</b> XIM <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>MARCH 19, 1967</b> to <b>APRIL 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 2, 1967</b> , and that death occurred at <b>605P</b> M, from causes and on the date stated above			
22a SIGNATURE <i>Milton Ginsberg</i>		22b DATE SIGNED <b>4/3/67</b>	
22c PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b DATE THEREOF <b>4-7-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>ACACIA CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>CHICAGO, ILLINOIS</b>
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>APR 5 1967</b>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

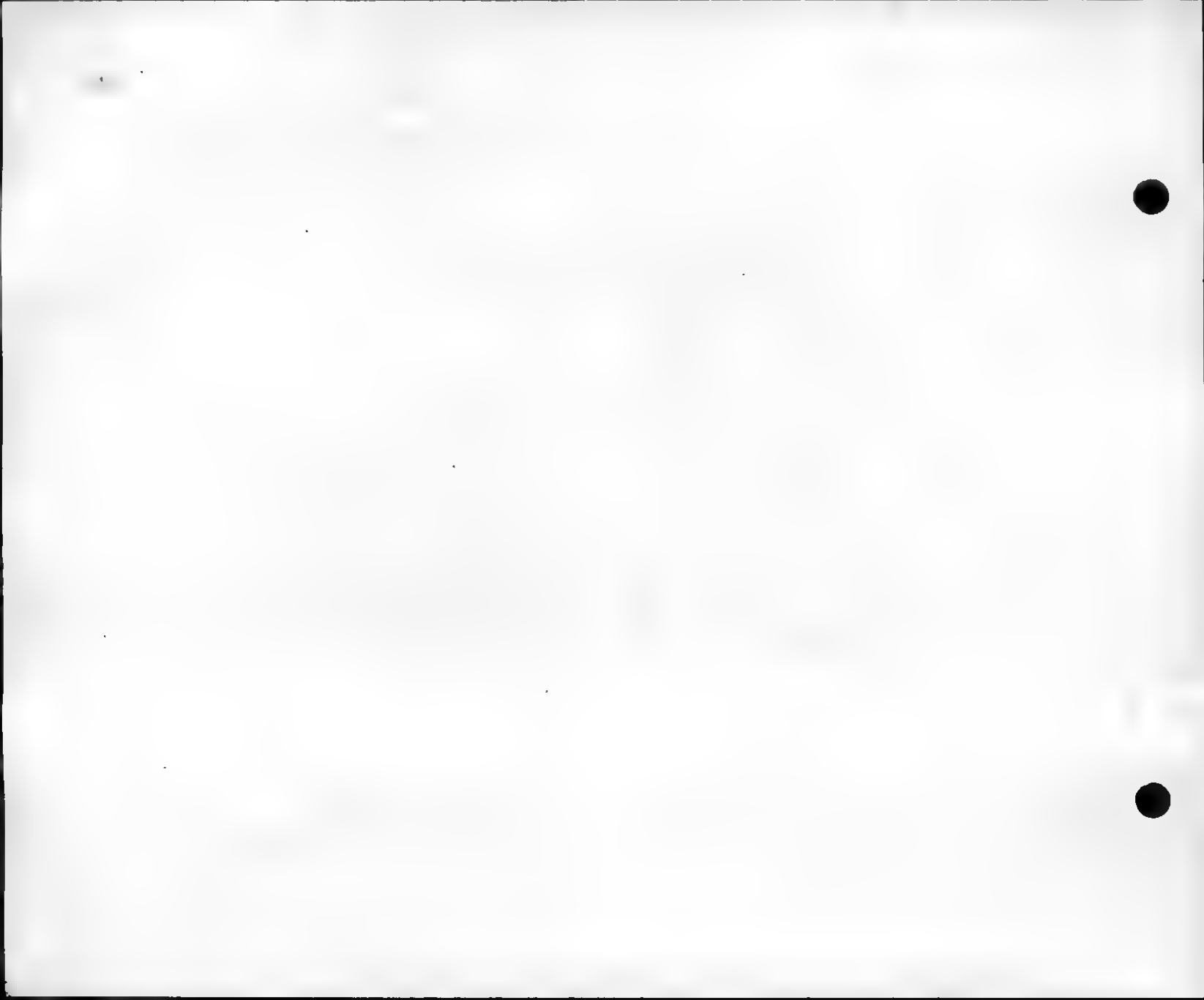
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04830

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased resided before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>103 BALTIMORE AVE</b>		a. STREET ADDRESS <b>103 BALTIMORE AVE</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>MYRTLE MAE MORRIS</b>		4 DATE OF DEATH Month Day Year <b>APRIL 20 1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DEC. 12, 1908</b>
9 AGE (In years last birthday) <b>58</b> YRS		10 IF UNDER 1 YEAR Months Days Hours Min <b>19 67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b KIND OF BUSINESS OR INDUSTRY <b>VIRGINIA</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JAMES K. SHIFLETT</b>		14 MOTHER'S MAIDEN NAME <b>MINNIE MORRIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOC. A. SECURITY NO. <b>JOHN K. MORRIS 103 BALTIMORE AVE</b>	
17 INFORMANT <b>JOHN K. MORRIS 103 BALTIMORE AVE</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Arterio-Sclerotic &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARDIO VASCULAR DISEASE</b> (c) <b>② Obesity</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>③ Thyroid-Pituitary Syndrome</b>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c TIME OF INJURY Month, Day, Year hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town, County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street city town or county) <b>6600 MORNINGTON</b>	
23a BURIAL, CREMATION, REMOVAL (specify) <b>BURIAL</b>		23b DATE THEREOF <b>APR. 24, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d CITY OR TOWN, COUNTY, STATE <b>BALTIMORE, CO MD</b>	
24 FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME-DUNDALK MD</b>		25a RECORDED BY REGISTRAR <b>APR 25 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22. DATE SIGNED <b>4/22/67</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

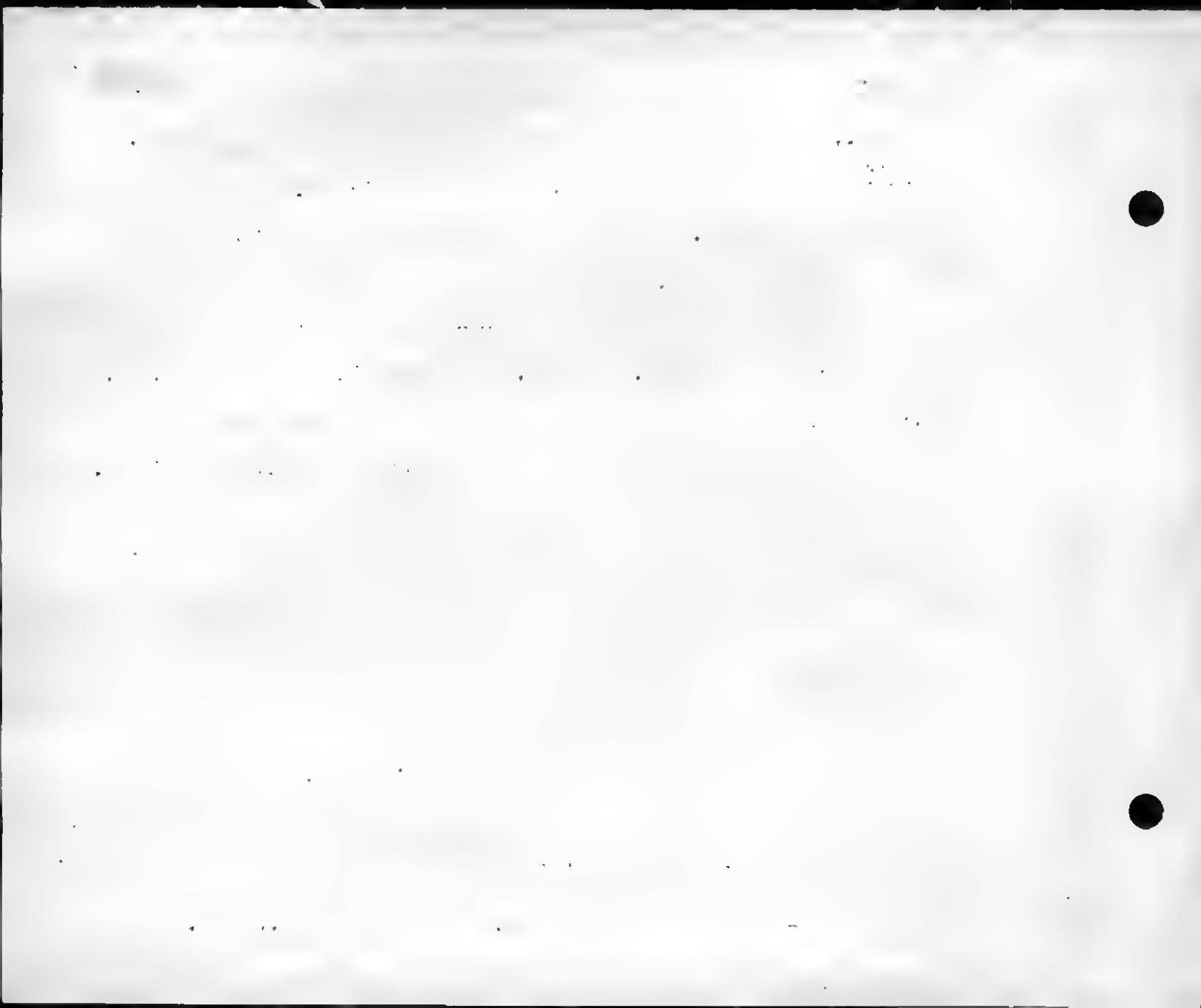
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04831

CERTIFICATE OF DEATH

04831

1. PLACE OF DEATH a. COUNTY <b>Balto.,</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.,</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sweet Air, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 265 Sweet Air Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD W. MOYER</b>		4. DATE OF DEATH <b>APRIL 17 19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-6-1902</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey Moyer</b>		14. MOTHER'S MAIDEN NAME <b>Dittwalked</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-5520</b>	
17. INFORMANT <b>Robert Moyer</b>		Address <b>Box 265 Sweet Air Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Coronary Insufficiency with Angina Pectoris.</b> DUE TO (c) <b>1 Hour</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 12, 1965</b> to <b>April 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1967</b> , and that death occurred at <b>9:04 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Henry L. McCorkle M.D.</b>		22b. DATE SIGNED <b>April 19, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry L. McCorkle M.D.</b>		22d. ADDRESS <b>Jarrettsville Pike, Phoenix, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-19-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cen.</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		25a. REG. BY REGISTRAR <b>APR 24 1967</b>	
ADDRESS <b>7401 Belair Road</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04832

CERTIFICATE OF DEATH

04832

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>Balto</u>	
c LENGTH OF STAY IN 1b <u>life</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <u>2115 Gwynn Oak Ave. 21207</u>	
3 NAME OF DECEASED (Type or print) <u>Ruth Amelia Mullineaux</u>		4 DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/9/02</u>
9 AGE (In years last birthday) <u>65</u> yrs		10 UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Richard William Mullineaux</u>		14 MOTHER'S MAIDEN NAME <u>Louisa Loos</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>215-05-4592</u>	
17 INFORMANT <u>Admission sheet</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of (L) lung</u> 163X DUE TO (b) <u>163X</u> DUE TO (c) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home form factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2-20</u> , 19 <u>67</u> , to <u>4/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> , 19 <u>67</u> , and that death occurred at <u>12:15 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Derek A Bruce</u>		22b DATE SIGNED <u>4/1/67</u>	
22c PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>		22d ADDRESS <u>G. B. M. C.</u>	
23a BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4/3/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Woodlawn, Maryland</u>
24 FUNERAL DIRECTOR <u>Kim J. Dickner &amp; Sons</u>		25a REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>Narch &amp; Penna Ave</u>		25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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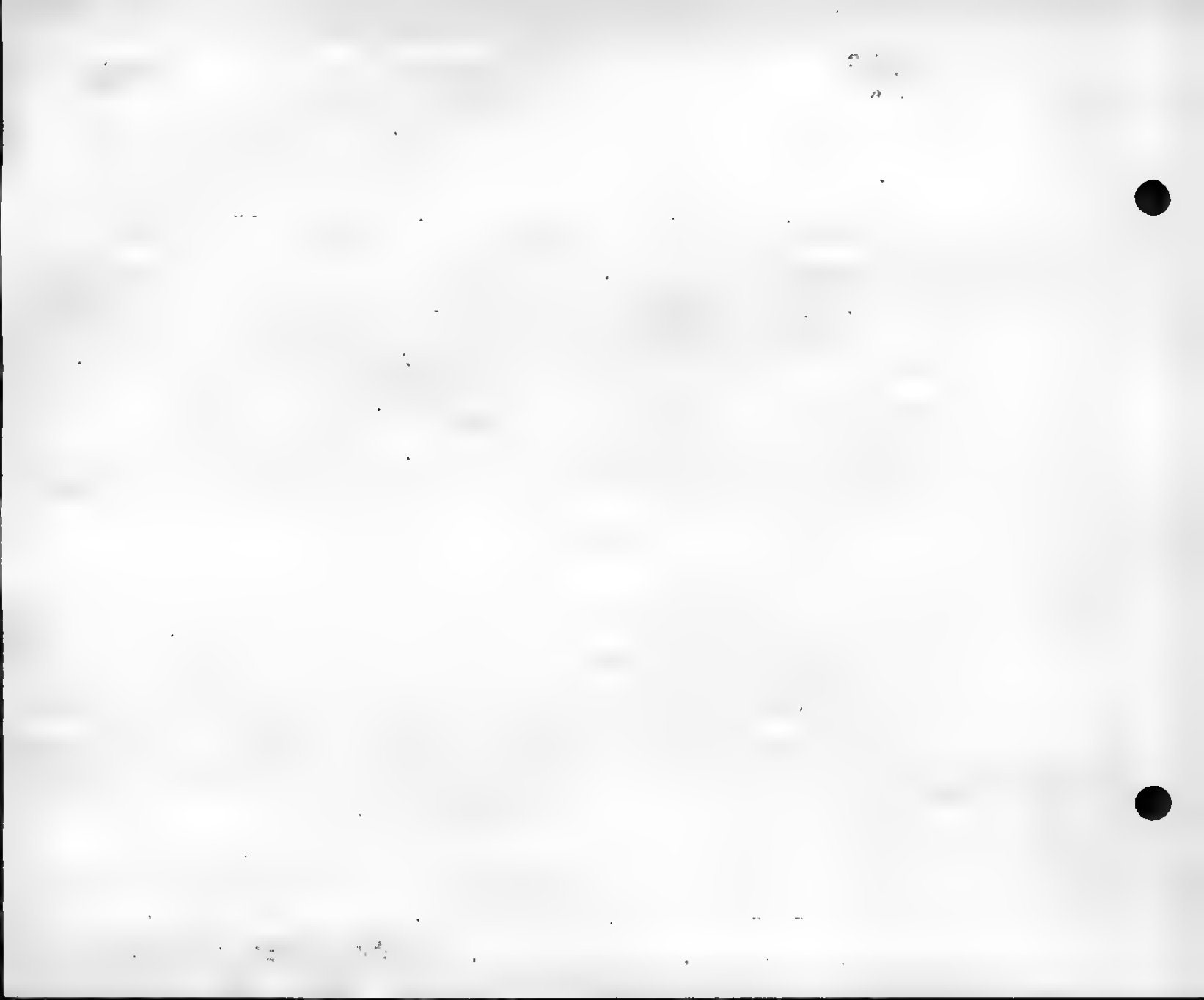
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04833

CERTIFICATE OF DEATH

04833

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 'b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Gothard Road--21093</u>				d. STREET ADDRESS <u>103 Gothard Road--21093</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Musch</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-1891</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. UNDER 1 YEAR Months <u>10</u> Days <u>15</u> Hours <u>15</u> Min <u>4</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kestler</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215033373D</u>		17. INFORMANT <u>Lester C. Musch</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>CHRONIC CONGESTIVE FAILURE</u> DUE TO (c) <u>RENAL PROLIFERIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>10-15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF BREAST (TREATMENT 1948)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>4/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March</u> 19 <u>67</u> , and that death occurred at <u>1 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John H. Hebb</u>				22b. DATE SIGNED <u>4/9/67</u>		22c. PHYSICIAN'S NAME (Type) <u>John H. Hebb</u>	
22d. ADDRESS <u>812 PARK AVE -- 21201</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Baltimore, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jorg</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04834

04834

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b> c. LENGTH OF STAY IN ID <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOXLEIGH NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>71 ADMIRAL BLVD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHESTER</b> Middle <b>N.</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>4</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-97</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD CONDUCTOR (RET)</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Elmer E. Myers</b>	
14. MOTHER'S MAIDEN NAME <b>Lilly Parthemore</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>195-07-0889</b>		17. INFORMANT (Wife) <b>Mrs. Esther Myers</b> Address <b>Md. 21222</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/29</b> , 19 <b>67</b> , to <b>4/9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-8</b> , 19 <b>67</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David J. Miller</b>		22b. DATE SIGNED <b>4-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David J. Miller</b>		22d. ADDRESS <b>Garrison Rd. Dundalk, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE OF DEATH <b>4/12/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 12 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

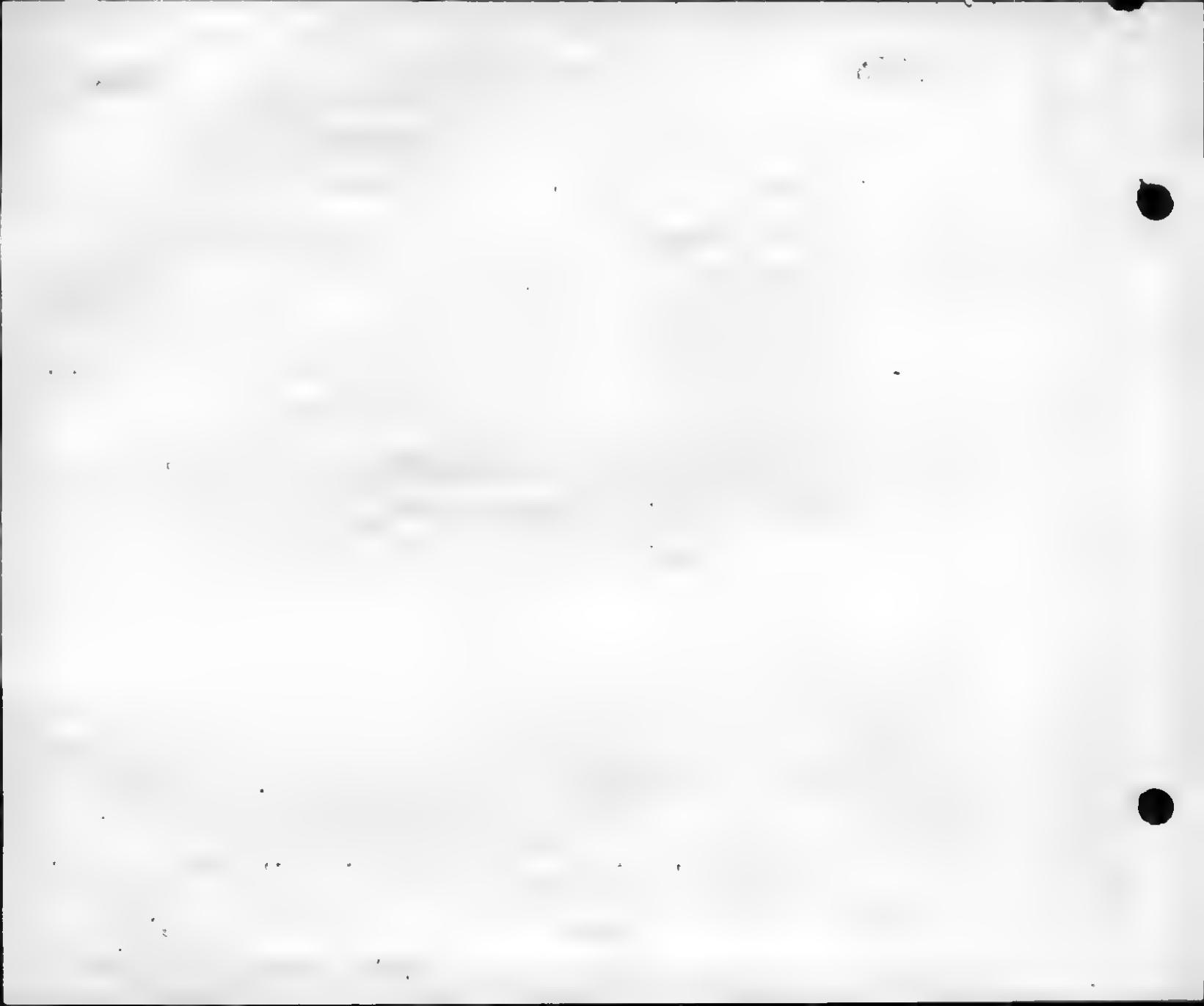
04835

**CERTIFICATE OF DEATH**

04835

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c LENGTH OF STAY IN 1b <b>15 yrs.</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d STREET ADDRESS <b>4329 Newport Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Rose Lee MYERS</b>				4. DATE OF DEATH Month Day Year <b>4 27 19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4-15-49</b>		9 AGE (In years last birthday) <b>18</b> yrs	10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b KIND OF BUSINESS OR INDUSTRY <b>none</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Horace Lee Myers</b>				14. MOTHER'S MAIDEN NAME <b>Clara Mary Killander</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>none</b>		17 INFORMANT Address <b>Rosewood Records, Owings Mills, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Down's Syndrome, Severe Mental Retardation.</b>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>8/3</b> , 1951, to <b>4/27</b> , 1967, that (X) (we) last saw the deceased alive on <b>4/27</b> , 1967, and that death occurred at <b>10:55 a.m.</b> causes and on the date stated above.							
22a SIGNATURE <i>Zsolt Koppanyi</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <b>4-27-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Zsolt Koppanyi, M.D.</b>				22d ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/1/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto National</b>		23d LOCATION (City or Town) (County) (State) <b>Frederick Rd, Md</b>	
24 FUNERAL DIRECTOR <b>Austin E. Donovan - 3818 Roland Ave</b>				25a RECD BY REGISTRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

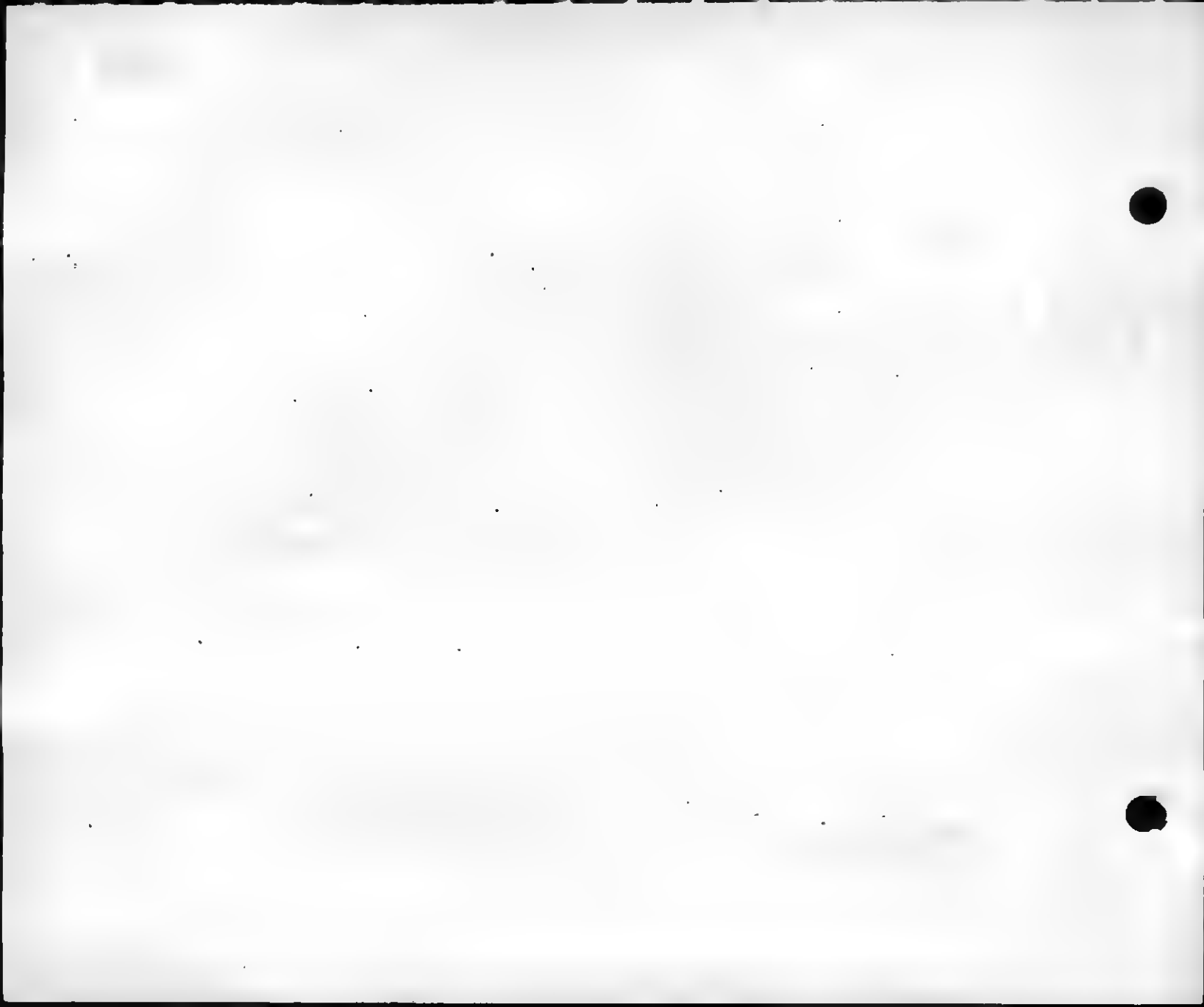
04837

04837

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Polinski Street</u>				e. STREET ADDRESS <u>111 Center Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Nelson</u> Last <u>Nelson</u>				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-1898</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER A YEAR Months <u>6</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Stafford Co., Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>UNK.</u>				14. MOTHER'S MAIDEN NAME <u>Ida Nelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>Mrs. Florence Fleming</u> Address <u>111 Center St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Failure</u> DUE TO (b) <u>Chronic Lung Disease</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Theo C Patterson</u>				22. DATE SIGNED <u>4/10/67</u>			
EXAMINER'S NAME (Type) <u>THEO C PATTERSON</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Morton E Dyett F.H.I.</u>				25a. REC'D BY REGISTRAR <u>Lauren St</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

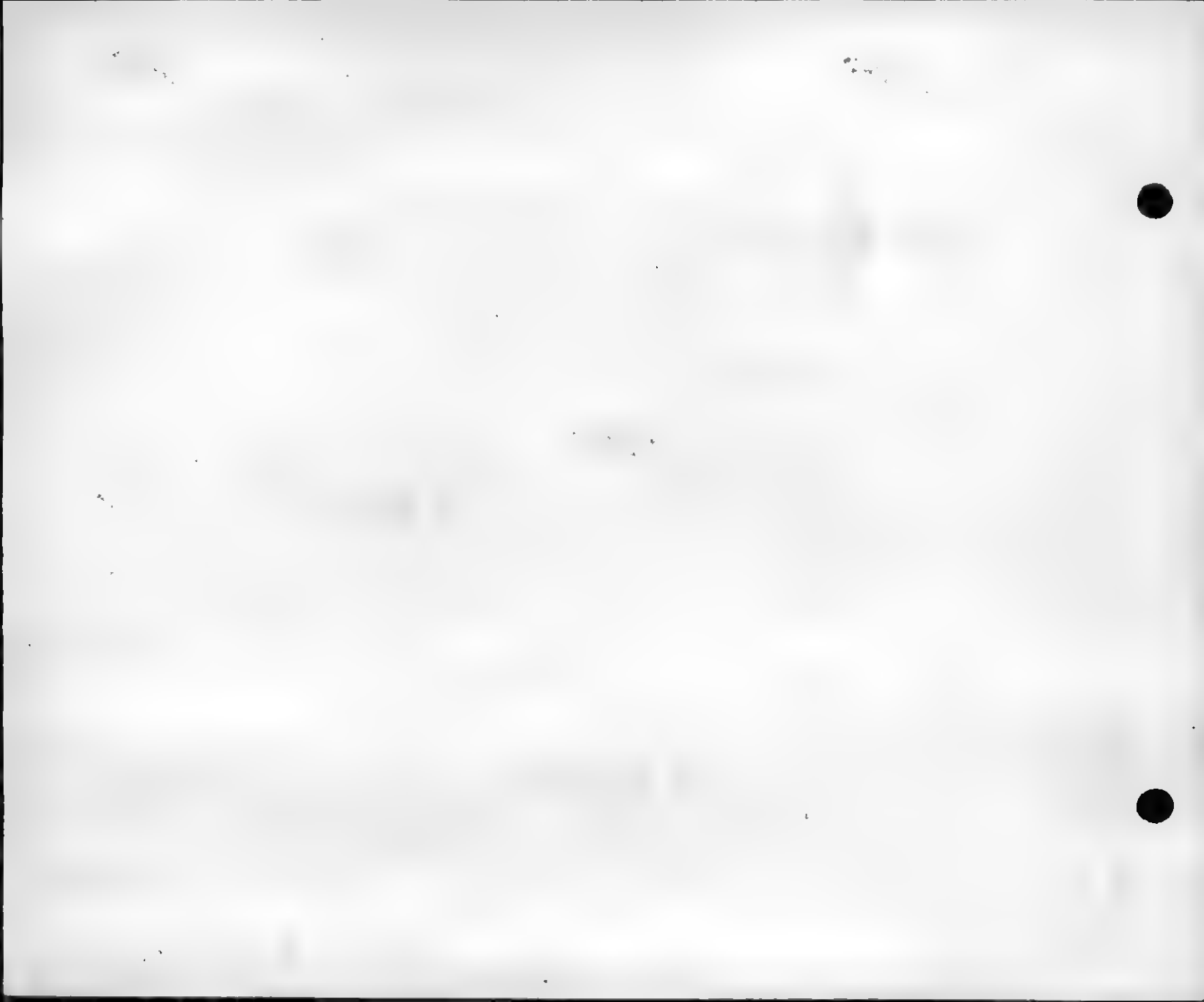
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34838

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22, Md</u>		c. LENGTH OF STAY IN lb <u>404</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22, Md</u>		d. STREET ADDRESS <u>111 Center St</u>	
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Center St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Malinda</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1900</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Stafford Co, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wesley Lee</u>		14. MOTHER'S MAIDEN NAME <u>Frances Thornton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>91-01-4524</u>	
17. INFORMANT <u>Florence G. Fleming</u>		Address <u>111 Center St #22</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetes Mellitus</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 AM</u> <u>6 PM</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1946</u> to <u>April 18, 1967</u> that (I) (we) last saw the deceased alive on <u>April 18, 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William C. Wade</u>		22b. DATE SIGNED <u>4/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Wade M.D.</u>		22d. ADDRESS <u>140 Oak Ave Dundalk 22, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clevers Oak Ch. Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Frederickburg VA</u>
24. FUNERAL DIRECTOR <u>Moeten &amp; Dyett F.H.</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

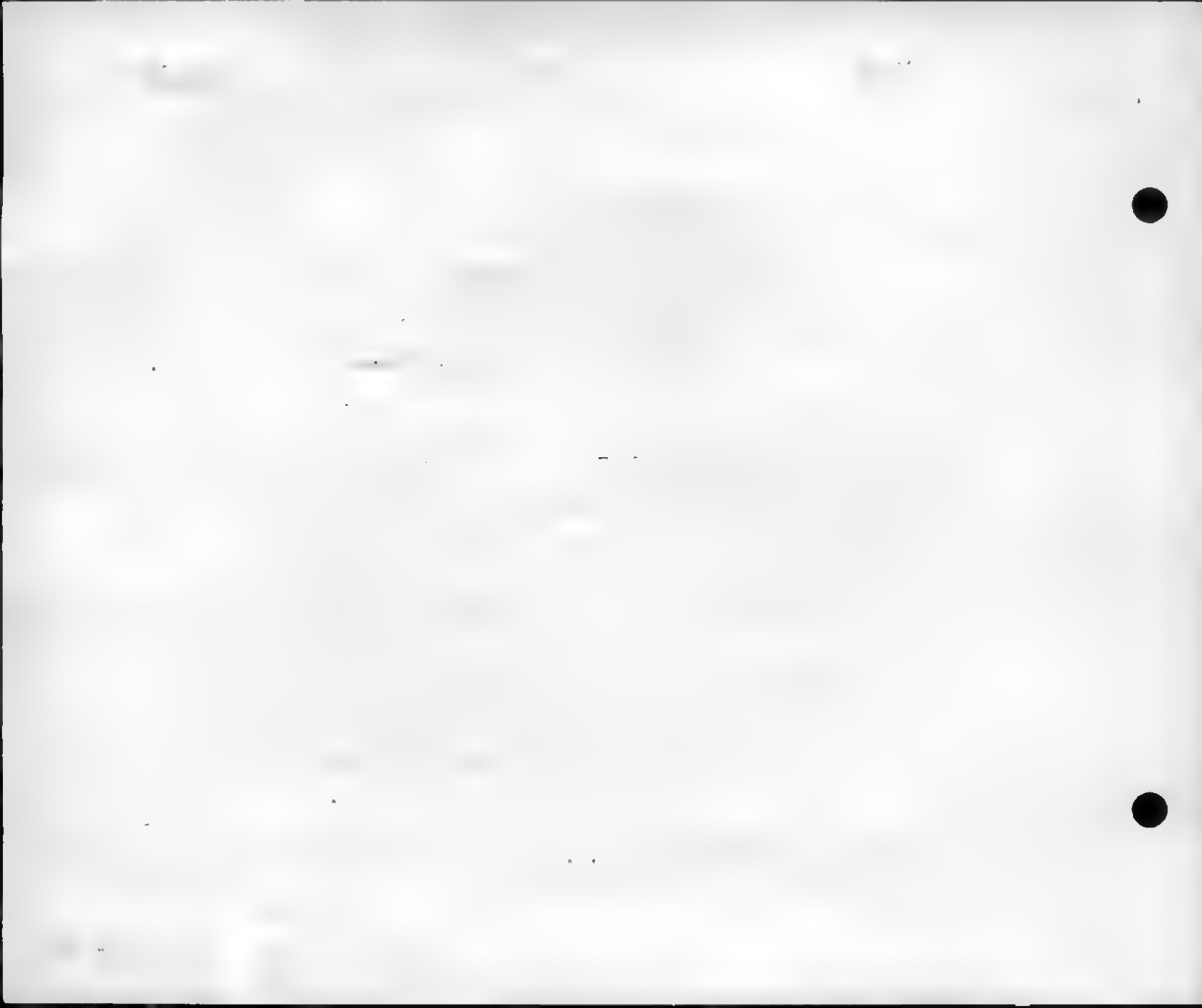
**CERTIFICATE OF DEATH**

04839

04839

<b>1. PLACE OF DEATH</b> a COUNTY <b>Baltimore</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Harford</b>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c LENGTH OF STAY in 1b <b>18yr8mth25dys</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood, Maryland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d STREET ADDRESS <b>none</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Martin Newmeister</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>April 29 19 67</b>				
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 14, 1897</b>		<b>9. AGE</b> (In years past birthday) yrs <b>69</b>	<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>factory</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>		
<b>13. FATHER'S NAME</b> <b>Henry Newmeister</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louise Nobelott</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-03-2088</b>		<b>17. INFORMANT</b> Address <b>Records: SPRING GROVE STATE HOSPITAL</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that</b> (this hospital) attended the deceased from <b>Aug. 4, 19 48</b> to <b>April 29, 19 67</b> , that (he) (we) last saw the deceased alive on <b>April 29, 19 67</b> , and that death occurred at <b>10:00</b> M, from causes and on the date stated above.								
<b>22a. SIGNATURE</b> <i>Stella Wachslar</i>				<b>22b. DATE SIGNED</b> <b>5-1-67</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Stella Wachslar, M.D.</b>		
<b>23a. BURIAL, CREMATION, REMOVA. (Specify)</b> <b>BURIAL</b>				<b>23b. DATE THEREOF</b> <b>5-5-67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. CARMEL CEM.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>John R. Miller - Montford &amp; Jefferson</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 4 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

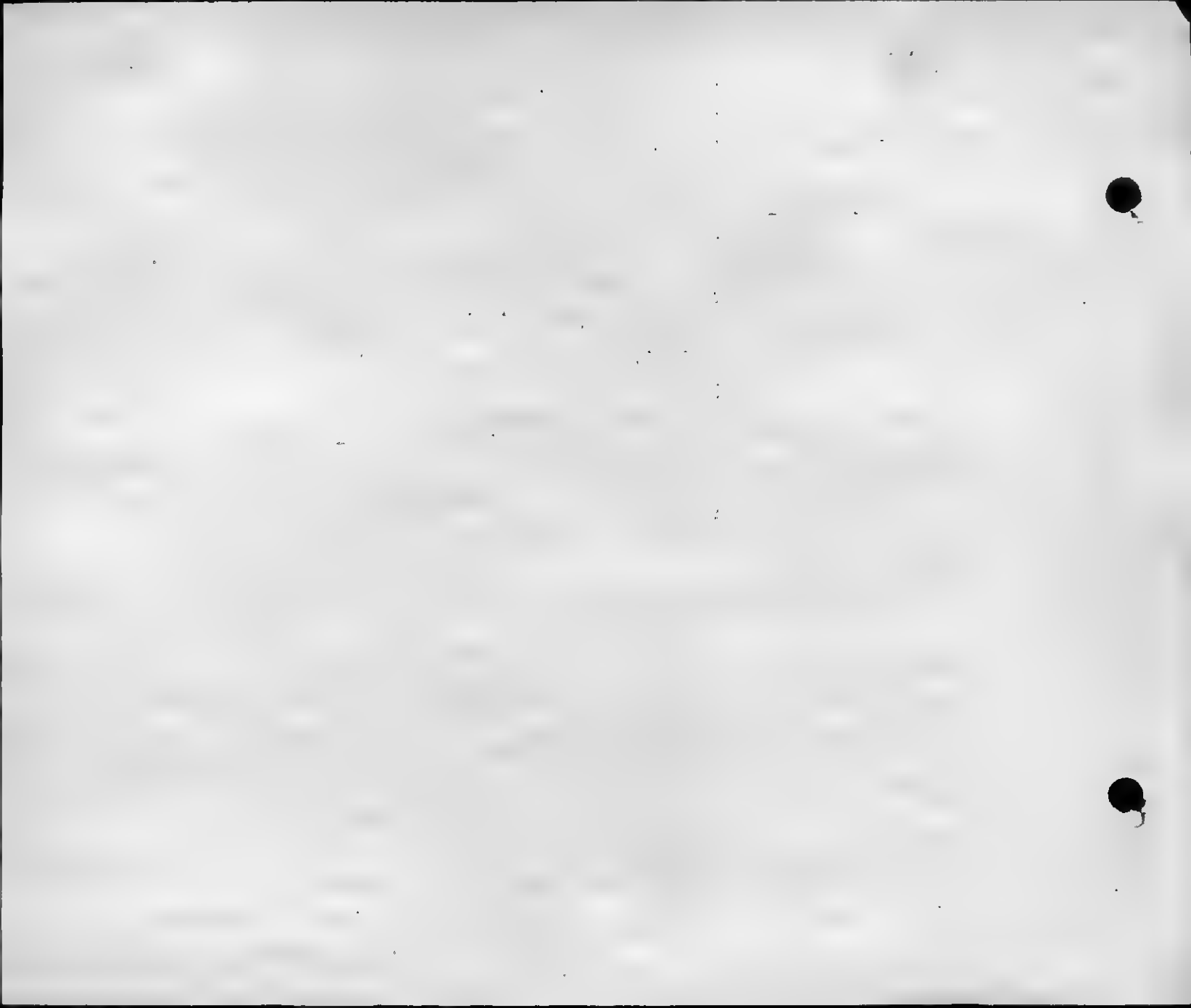
## CERTIFICATE OF DEATH

34840

Item 2 Filed 9/30/67 4/11/67 KK

04840

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN It <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House-in-the-Pines - Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>2012 Milford Avenue</b> <b>16 Eustling Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George</b> First Middle Last <b>Nice</b>		4. DATE OF DEATH <b>April 2, 1967</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1878</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Distillery</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>House in the Pines - Catonsville records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO <b>appearing at side of body</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Serility</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> to <b>Apr 2, 1967</b> that (I) (we) last saw the deceased alive on <b>Apr 2, 1967</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <b>M Paul Byerly</b> 22c. PHYSICIAN'S NAME (Type) <b>M Paul Byerly</b>		22d. ADDRESS <b>58 W York Rd Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Zickman &amp; Son</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

24841

04841

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 21234</b>	
c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>3017 Woodhome Ave., #34</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Charles J NOHE</b>		4 DATE OF DEATH Month Day Year <b>April 24, 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>January 4, 1897</b>
9 AGE (In years lost birthday) <b>70</b> yrs		10 UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinists</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>control Co.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacobs Nohe</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hierstetter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>214-01-5311</b>	
17. INFORMANT <b>Loretta Nohe</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>332X Brain infarct</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>April 20, 1967</b> , to <b>April 24, 1967</b> , that <b>NO</b> (we) last saw the deceased alive on <b>April 24, 1967</b> , and that death occurred at <b>8:40 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>April 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-27-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24 FUNERAL DIRECTOR <b>C.F. Evans &amp; Son 8802 Harford Road</b>		25a REC'D BY REGISTRAR DATE <b>APR 27 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

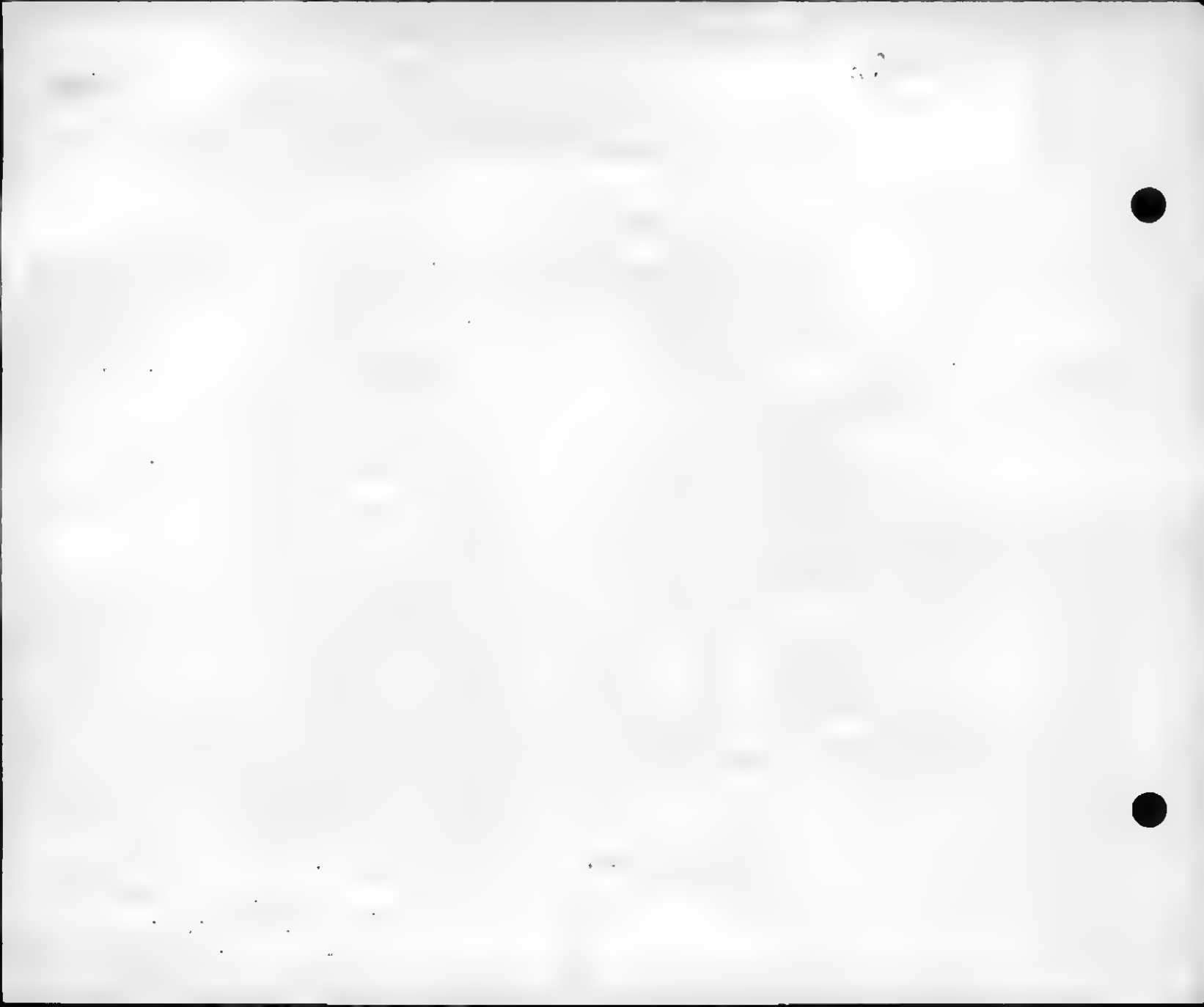
04842

**CERTIFICATE OF DEATH**

04842

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> c. LENGTH OF STAY IN b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor, 509 E. Joppa Road</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> d. STREET ADDRESS <b>508 Chadwick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Anna Margaret Norris</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>April 4, 19 67</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov. 21, 1882</b>
<b>9. AGE</b> (in years last birthday) <b>84</b>	<b>10a. US. AL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Henry Froehlich</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Roose</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO</b>  	
<b>17. INFORMANT</b> <b>W. Landy Cook, 508 Chadwick Road.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE COLONS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)  	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  	<b>20f. (City or town) (County) (State)</b>  
<b>21. I certify that (I) (this hospital) attended the deceased from 3-13-1967, to 4-4-1967, that (I) (we) last saw the deceased alive on 4-3-1967 and that death occurred at 11 P.M. from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Luis J. Elias M.D.</b>		<b>22b. DATE SIGNED</b> <b>4/6/67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Luis J. Elias M.D.</b>		<b>22d. ADDRESS</b> <b>Northern Pkwy. &amp; Loch Raven Blvd.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>4/7/67</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn Cemetery</b>	<b>23d. LOCATION (City or town) (County) (State)</b> <b>APR 10 1967 Charles Jones</b>
<b>24. FUNERAL DIRECTOR</b> <b>Ullrich Funeral Home, Dundalk, Md.</b>		<b>25a. REC'D BY REG. STRAR</b> <b>DATE APR 10 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

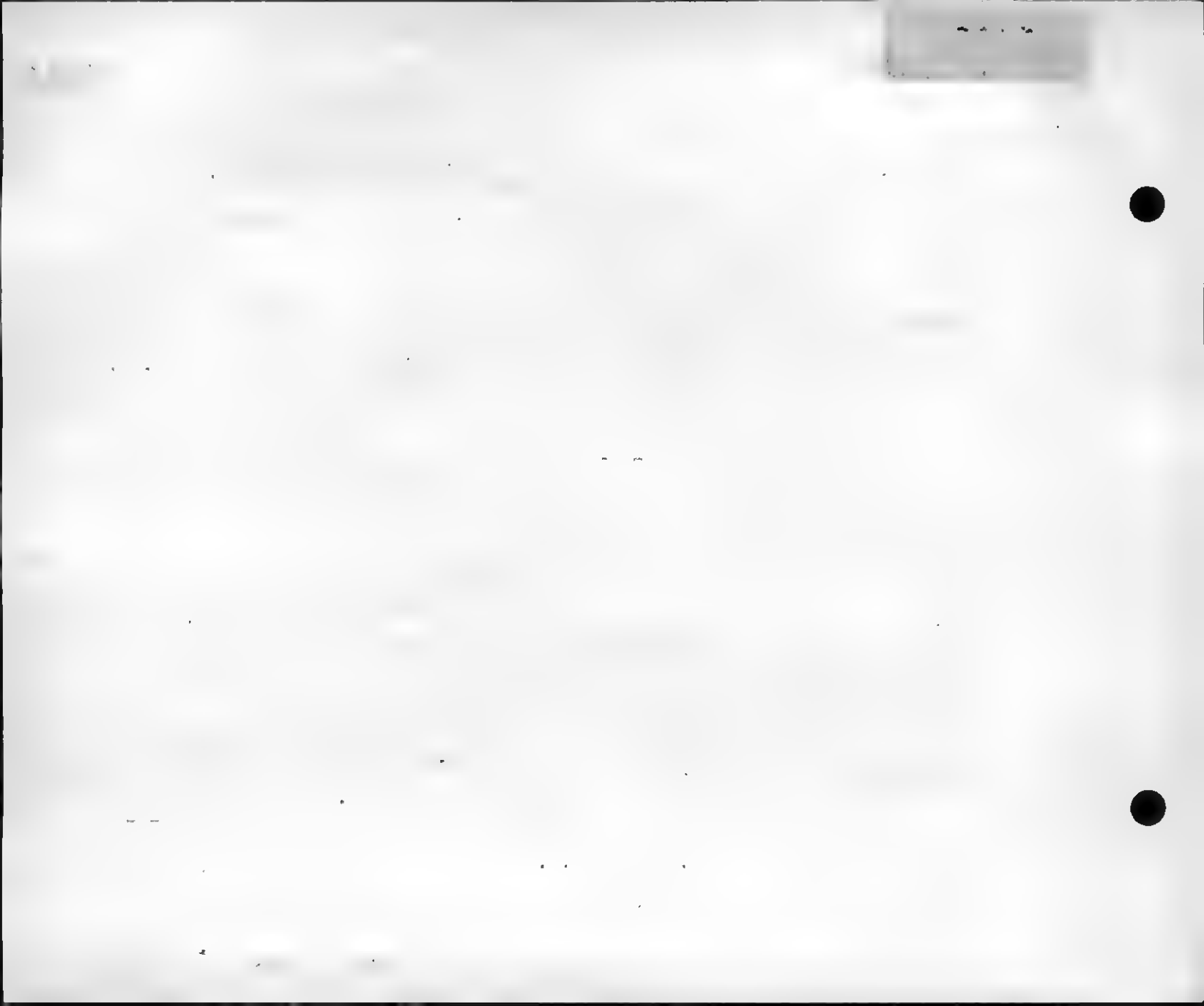
04843

**CERTIFICATE OF DEATH**

04843

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>2yr5mth11dys</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>2412 Fairlawn Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Mamie</b>		First Middle Last <b>Obier</b>		4 DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5-20-1882</b>	9 AGE (in years birth day) yrs <b>84</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Taylor Clark</b>				14. MOTHER'S MAIDEN NAME <b>KING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>230-12-3586</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4341</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>						19 WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (A) (this hospital) attended the deceased from <b>Nov. 16</b> , 19 <b>64</b> , to <b>April 27</b> , 19 <b>67</b> , that (B) (we) last saw the deceased alive on <b>April 27</b> , 19 <b>67</b> , and that death occurred at <b>8:30</b> M. from causes and on the date stated above							
22a SIGNATURE <i>Anthony J. Young</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <b>4-8-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4-29-1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>SUITLAND MD</b>	
24 FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		ADDRESS <b>5801 Cleveland Ave. Pikesville</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04844

04844

1 PLACE OF DEATH a COUNTY <u>Baltimore County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp.</u>		d STREET ADDRESS <u>5219 Windsor Mill Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Marshall G Orndorff</u>		4 DATE OF DEATH <u>4 - 18 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1899</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk A.A.R. Bureau</u>		9b KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. R.R.</u>	9c AGE (In years last birthday) <u>68</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk A.A.R. Bureau</u>		10b KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. R.R.</u>	10c BIRTHPLACE (County & State or foreign country) <u>W. Virginia</u>
11 FATHER'S NAME <u>Alexander Orndorff</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 MOTHER'S MAIDEN NAME <u>Hannah Stickley</u>		14 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u></u>	
17 INFORMANT <u>Mrs. Arleen M. Orndorff</u>		Address <u>5219 Windsor Mill Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>			
DUE TO (b) <u>Ischemic Heart Disease</u>			
DUE TO (c) <u>Congestive heart failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> , 19 <u>67</u> , to <u>4-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-18</u> , 19 <u>67</u> , and that death occurred at <u>9 A.</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>de Jager</u>		22b. DATE SIGNED <u>4-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>de Jager</u>		22d. ADDRESS <u>BCGH</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-22-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Queens Point</u>		23d. LOCATION (City or Town) (County) (State) <u>Keyser, W.Va.</u>	
24. FUNERAL DIRECTOR <u>Howard Strong</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>	
Address <u>3207 W. North Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



4 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04845

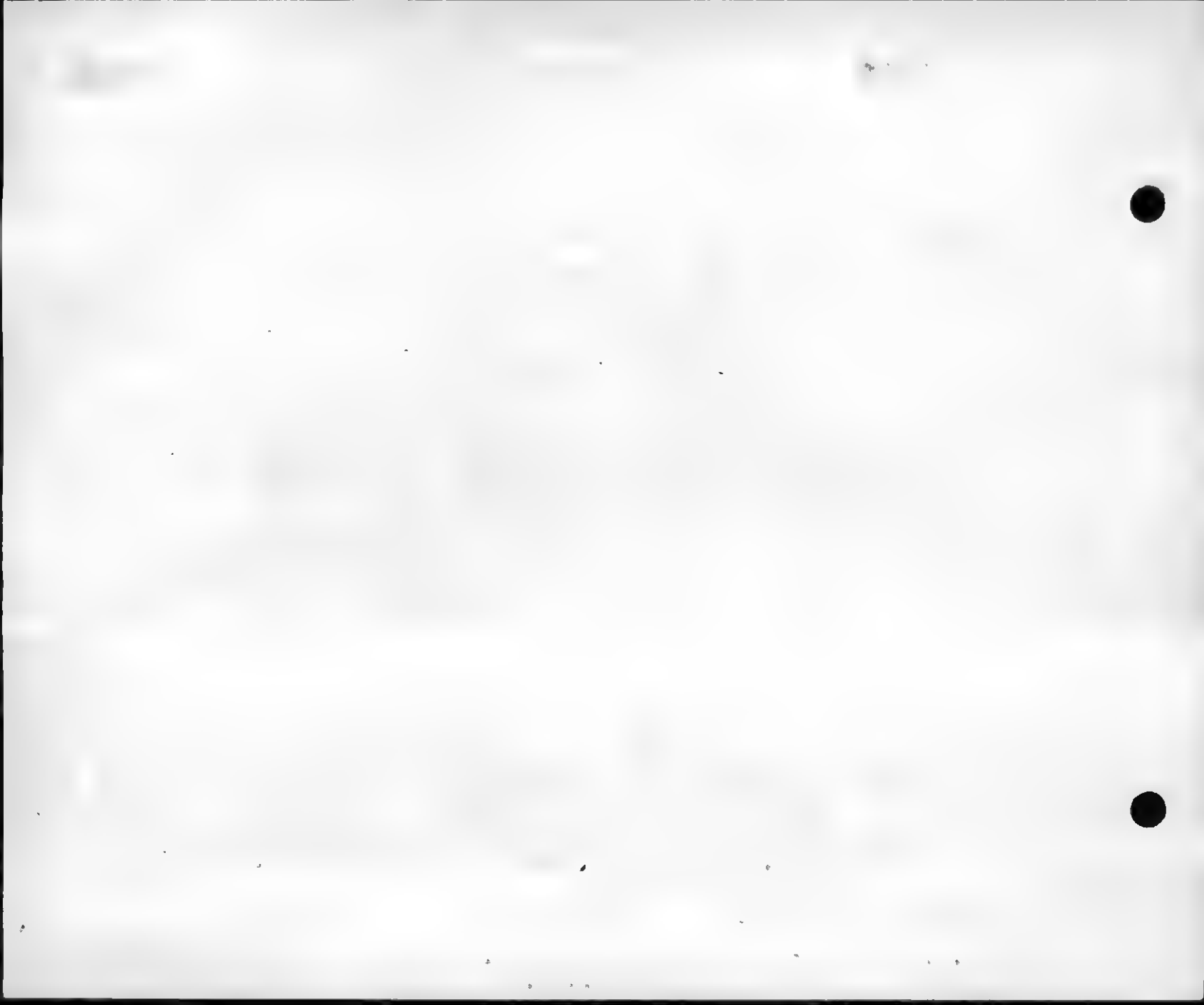
CERTIFICATE OF DEATH

04845

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. in an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write PHR. and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med Center</u>		e. STREET ADDRESS <u>7822 Ruxwood Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Hamilton</u> First <u>HAZEL</u> Middle <u>QUEENS</u> Last		4 DATE OF DEATH <u>April 21</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-08-88</u> 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - EDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Gwinn Fardon</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN-BELLE SMITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>UNKNOWN - NO</u>		16. SOCIAL SECURITY NO <u>213-03-2758</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Terminal Ca of Pancreas with</u> DUE TO (c) <u>Metastasis. Acute urinary retention</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 20, 1967</u> , to <u>April 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-20-67</u> , and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Francisco L. Coatauco, MD</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/21/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Francisco L. Coatauco</u>		22d. ADDRESS <u>Greater Balto. Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>4-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
ADDRESS <u>4905 York Rd. Balto., Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4846

04846

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>623 Murdock Rd.</b>				d STREET ADDRESS <b>623 Murdock Road</b>			
3 NAME OF DECEASED (Type or print) <b>Mary Theresa Papania</b>				4 DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1967</b>			
5 SEX <b>female</b>		6 COLOR OR RACE <b>white</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>June 12, 1900</b>	
9 AGE (In years last birthday) <b>66</b> yrs.		10 IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>15</b> Min.		11 BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer Balto. City Court H'se</b>				10b KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME - <b>Pirrone</b>				14 MOTHER'S MAIDEN NAME <b>Caroline Vikirito</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>				16 SOCIAL SECURITY NO. <b>219-10-0556</b>			
17 INFORMANT <b>Mrs. Adeline McCauley</b>				Address <b>6209 Leith Walk</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Occlusion</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerotic Hypertensive Heart Disease</b> DUE TO (c) <b>Cardiovascular Disease</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>4/30/67</b>			
23a BURIAL CREMATION, REINTERMENT				23b DATE THEREOF <b>5/3/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mausoleum Balto., Md.</b>	
23d LOCATION (City or town)				23e (County)		23f (State)	
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd. Balto., Md. 21212</b>		25a RECORD BY REGISTRAR <b>MAY 3 1967</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

34847

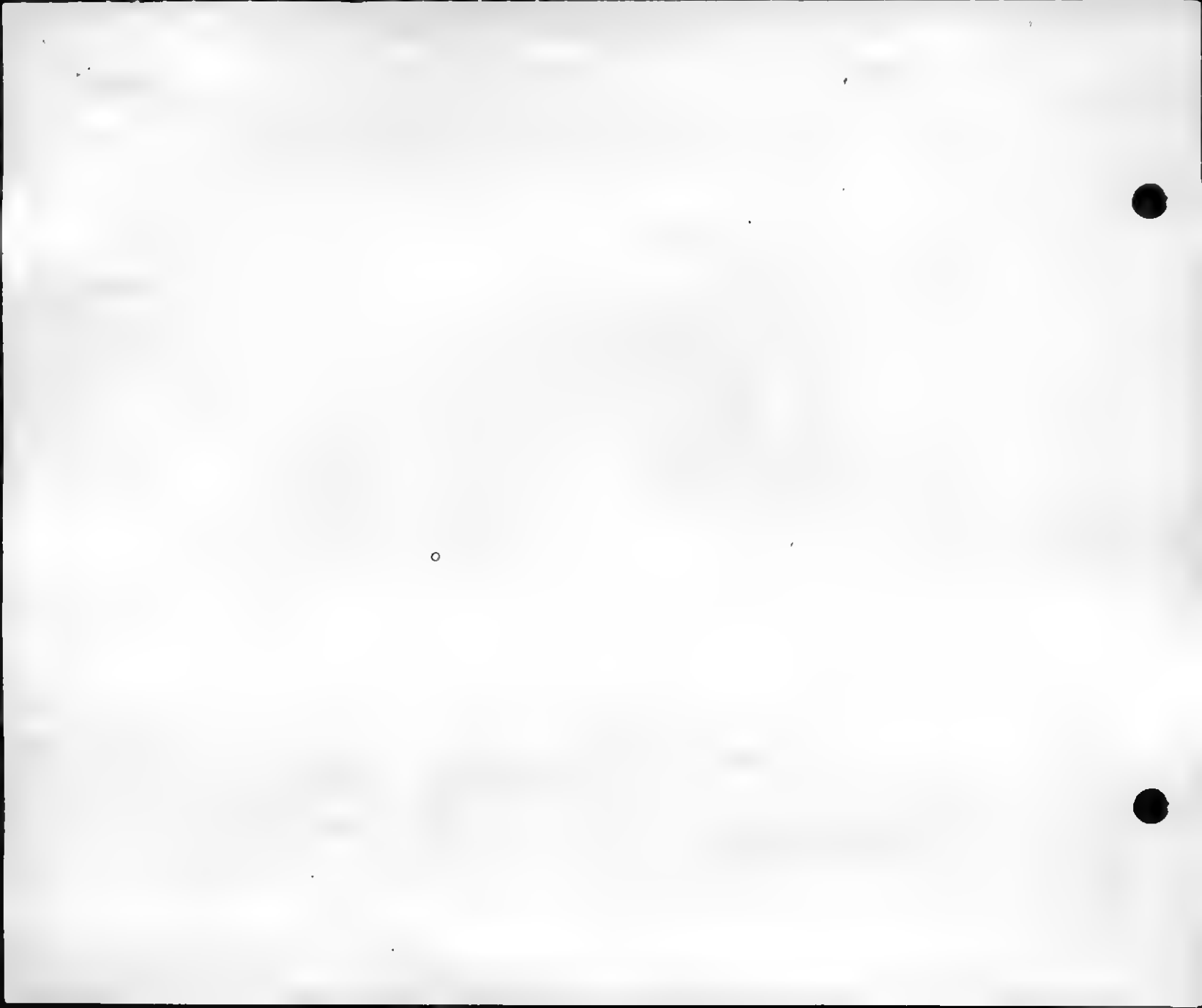
## CERTIFICATE OF DEATH

04847

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRAY MANOR</u>		c. LENGTH OF STAY IN 1b <u>BALTO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2810 Mc COMAS</u>		d. STREET ADDRESS <u>3808 BANK ST</u>	
3. NAME OF DECEASED (Type or print) <u>GLADYS PARADISE</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-1901</u>
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL SPARKS</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MICHAEL PARADISE</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ca. of splenic flexum of colon c. Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1966</u> to <u>4/16</u> , 1967, that (I) (we) last saw the deceased alive on <u>4/13</u> , 1967, and that death occurred at <u>9:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph R. Liberato</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH R. LIBERATO, M.D.</u>		22d. ADDRESS <u>3528 BALTIMORE - BALTIMORE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APR. 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEK ORTHODOX</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>J.E. CONNELLY SONS</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
ADDRESS <u>300 MACE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

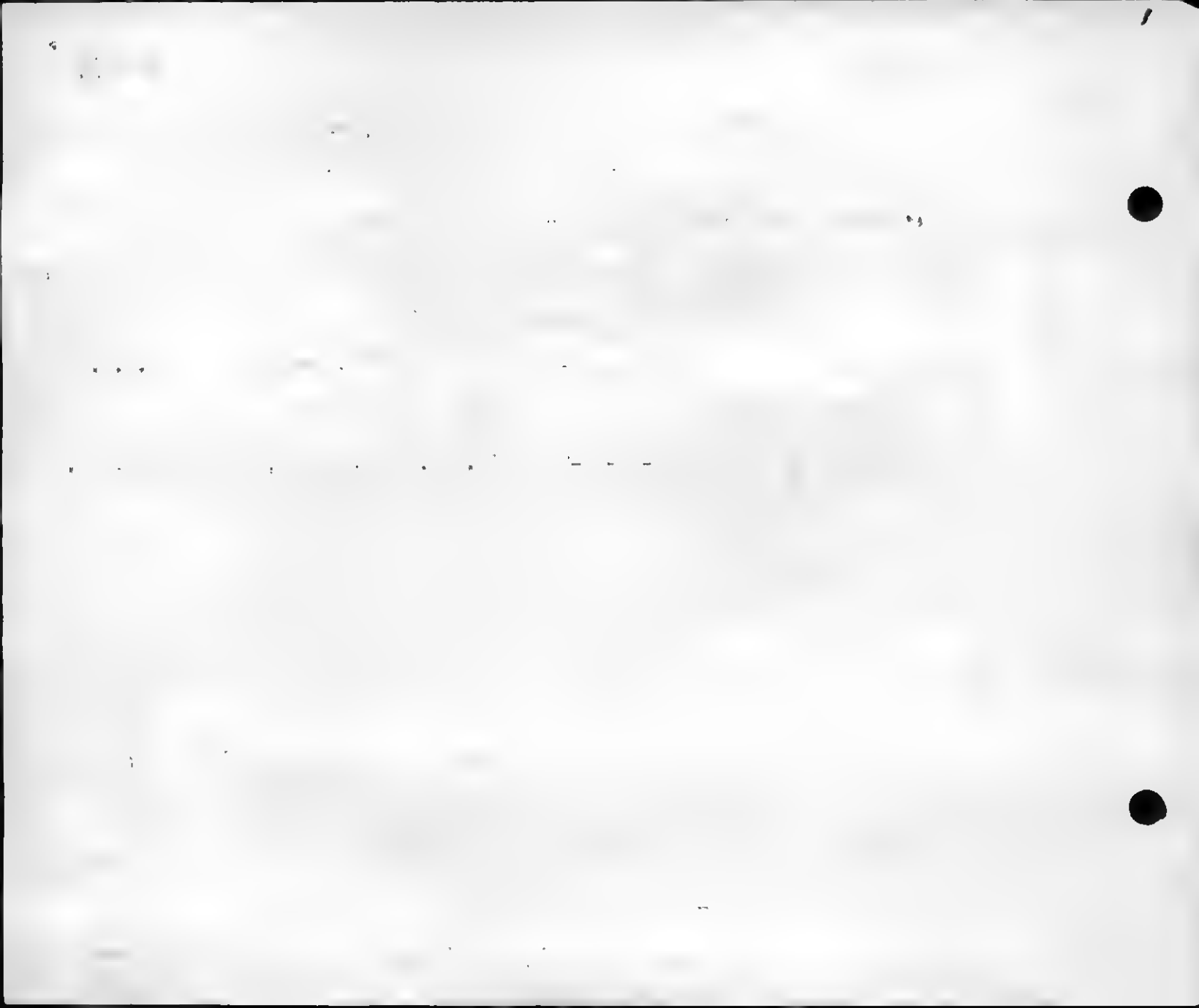
04848

CERTIFICATE OF DEATH

04848

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
c. LENGTH OF STAY IN It <b>11 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>331 Bestgate Road</b>	
3 NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>EDWARD</b> Last <b>PARKER</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11/18/20</b>
9. AGE (In years last birthday) <b>46</b>		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tractor Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hollie Parker</b>		14. MOTHER'S MAIDEN NAME <b>Laura <del>Wyle</del> Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>214-114-04-95</b>	
17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF UPPER ESOPHAGUS WITH METASTASIS</b> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>April 2</b> , 19 <b>67</b> to <b>April 13</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>April 13</b> , 19 <b>67</b> , and that death occurred at <b>11:59 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>4/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE TIME OF <b>April 16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pinelawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis, Maryland</b>
24. FUNERAL DIRECTOR <b>CHARLES HICKS FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04849

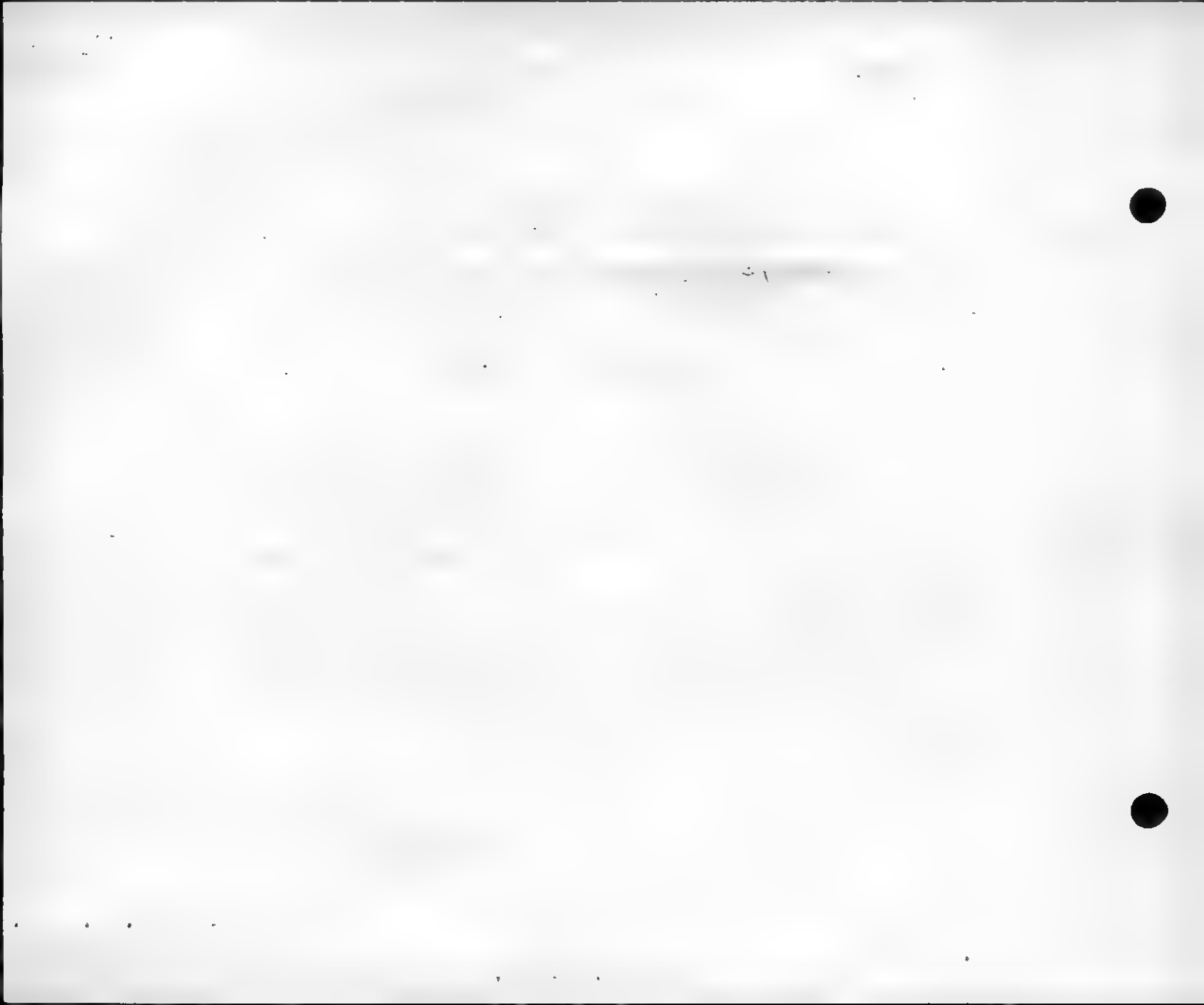
**CERTIFICATE OF DEATH**

04849

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN IT <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7108 Rogers Court</u>		d. STREET ADDRESS <u>7108 Rogers Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JESSIE ELIZABETH Parkhurst</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-05-16</u>
9. AGE (In years lost birthday) <u>51</u> yrs		10. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David McLean</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE E. MAC-NEAL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Pt. chart.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>11-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Metastasis, Carcinoma of ovary</u> DUE TO (c) <u>7 mos. (7 mo)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mins.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>67</u> to <u>4-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-17</u> , 19 <u>67</u> , and that death occurred at <u>11:50</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>V.R. Batoyon</u>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u>		22d. ADDRESS <u>67016 Charles St., Balto, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/20/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d. LOCATION (City or Town) (County) (State) <u>Parkville, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co., 4905 York Rd. Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



04850

04850

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY in 1b <u>7 WEEKS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD MARYLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL Center</u>				d. STREET ADDRESS <u>118 MARYLAND AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>PARKS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1906</u>	9. AGE (in years last birthday) <u>60</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCH MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARVEL HALL CUTLERY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CRISFIELD MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY (NM) PARKS</u>				14. MOTHER'S MAIDEN NAME <u>MADRIX (DOLLIE MADRIX)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-05-5725</u>		17. INFORMANT <u>ADMISSION sheet</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio - Resp. Failure</u> DUE TO (b) <u>Bronchogenic carcinoma with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hypertensive and cerebral metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>2/13/1967</u> , to <u>4/4/1967</u> , that (H) (we) last saw the deceased alive on <u>4/4/1967</u> , and that death occurred at <u>7 P.</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Dennis Chan</u>				22b. DATE SIGNED <u>4/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN MD.</u>	
22d. ADDRESS <u>GBMC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNNYRIDGE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CRISFIELD, MD</u>	
24. FUNERAL DIRECTOR <u>Bradshaw, Crisfield, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04851

CERTIFICATE OF DEATH

04851

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c LENGTH OF STAY IN 1b <u>13-1</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>				d. STREET ADDRESS <u>204 E. Joppa Road</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lutie</u> Middle <u>A.</u> Last <u>Parsons</u>				4 DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1967</u>			
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-30-1894</u>	9 AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>  </u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Alice Blakley</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>215-01-1467</u>		17. INFORMANT <u>Leroy W. Dollinger</u> Address: <u>Mt. Vista Rd. Bradshaw, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18, 1965</u> , to <u>4/5, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/13, 1967</u> , and that death occurred at <u>12:01 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>C. Edward Leach</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/6/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C EDWARD LEACH</u>		22d. ADDRESS <u>14 E. Eager St.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>4-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a REC'D BY REGISTRAR DATE <u>APR 7 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11/20/11



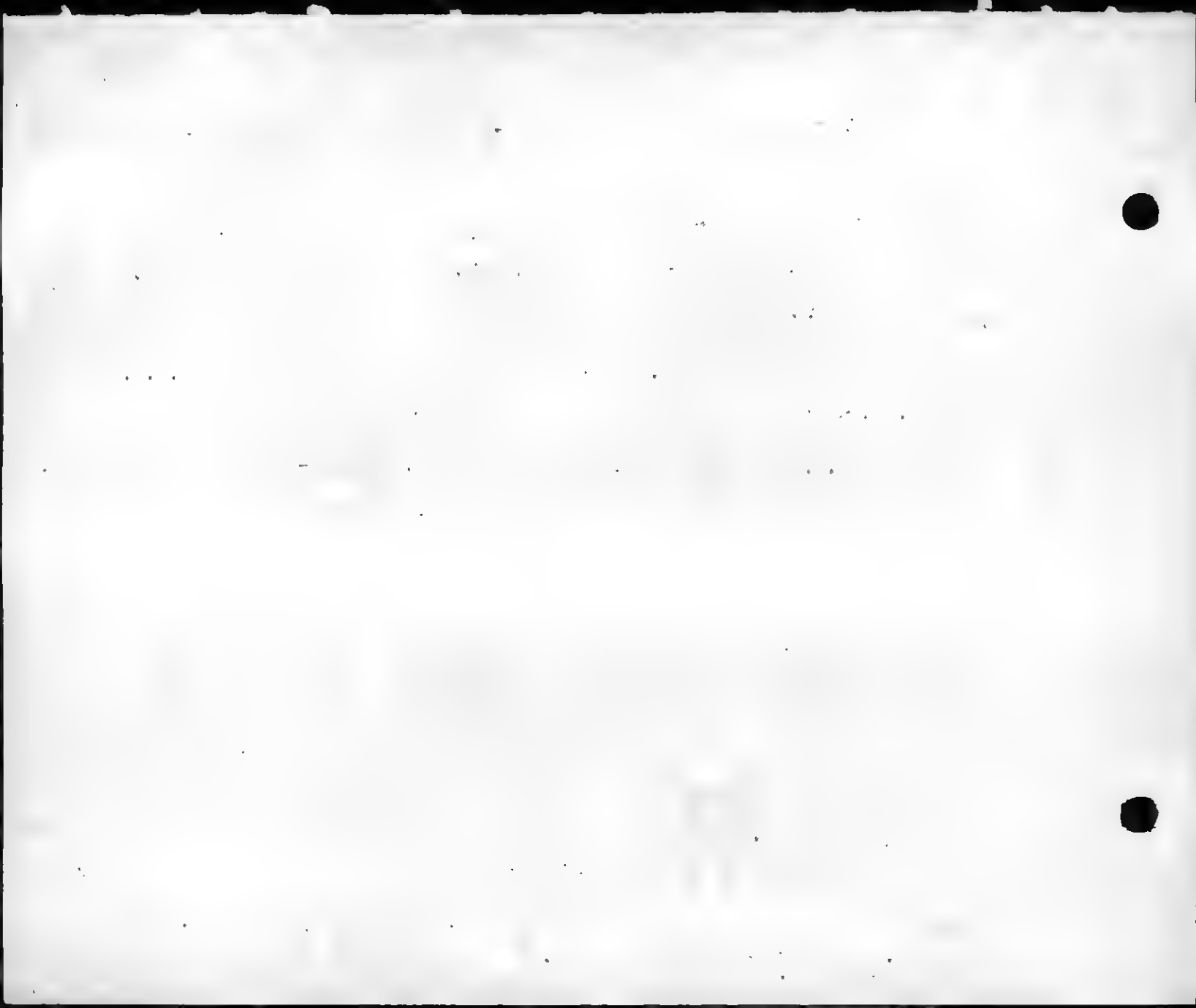
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the Chief Medical Examiner's Office. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04852

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Beth. Steel Hospital</b>		d. STREET ADDRESS <b>Sparrow Point Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Vernon</b> Middle <b>B.</b> Last <b>PARSONS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/20</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Nannie Price</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>579-36-6505</b>	
17. INFORMANT <b>Beatrice J. Parsons-8202 Peach Orchard Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C Patterson</b>		22. DATE SIGNED <b>4/24/67</b>	
EXAMINER'S NAME (Type) <b>THEO C PATTERSON</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Family Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pittsylvania Co.-Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert C. Altenburg - 6009 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>APR 26 1967</b>	
Funeral Home, Inc.		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					04853						
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE HALL</u>			c. LENGTH OF STAY IN 1b <u>hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE HALL, Md</u>			d. STREET ADDRESS <u>Hunter Mill Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREY Stone Rd.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>PARTRIDGE</u>					4. DATE OF DEATH Month <u>APR</u> Day <u>16</u> Year <u>1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1945</u>		9. AGE (In years last birthday) <u>21</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Repair</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William T. Partridge</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth FAKASEY</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Viet Nam</u>					16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Elizabeth Partridge</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE TRAUMATIC injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STUCK AT TIRE pole while riding a motorcycle</u>						
20c. TIME OF INJURY Month, Day, Year <u>4/16 1967</u> Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>WHITE HALL, BALTIMORE, Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>A. M. France</u>					M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>4/16/67</u>		
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>							DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Apr. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>W. C. Cook-Brooks Towson</u>					ADDRESS <u>1050 York Road Towson, Md. 21204</u>		25a. REC'D BY REGISTRAR <u>DATE</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		
APR 20 1967											



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

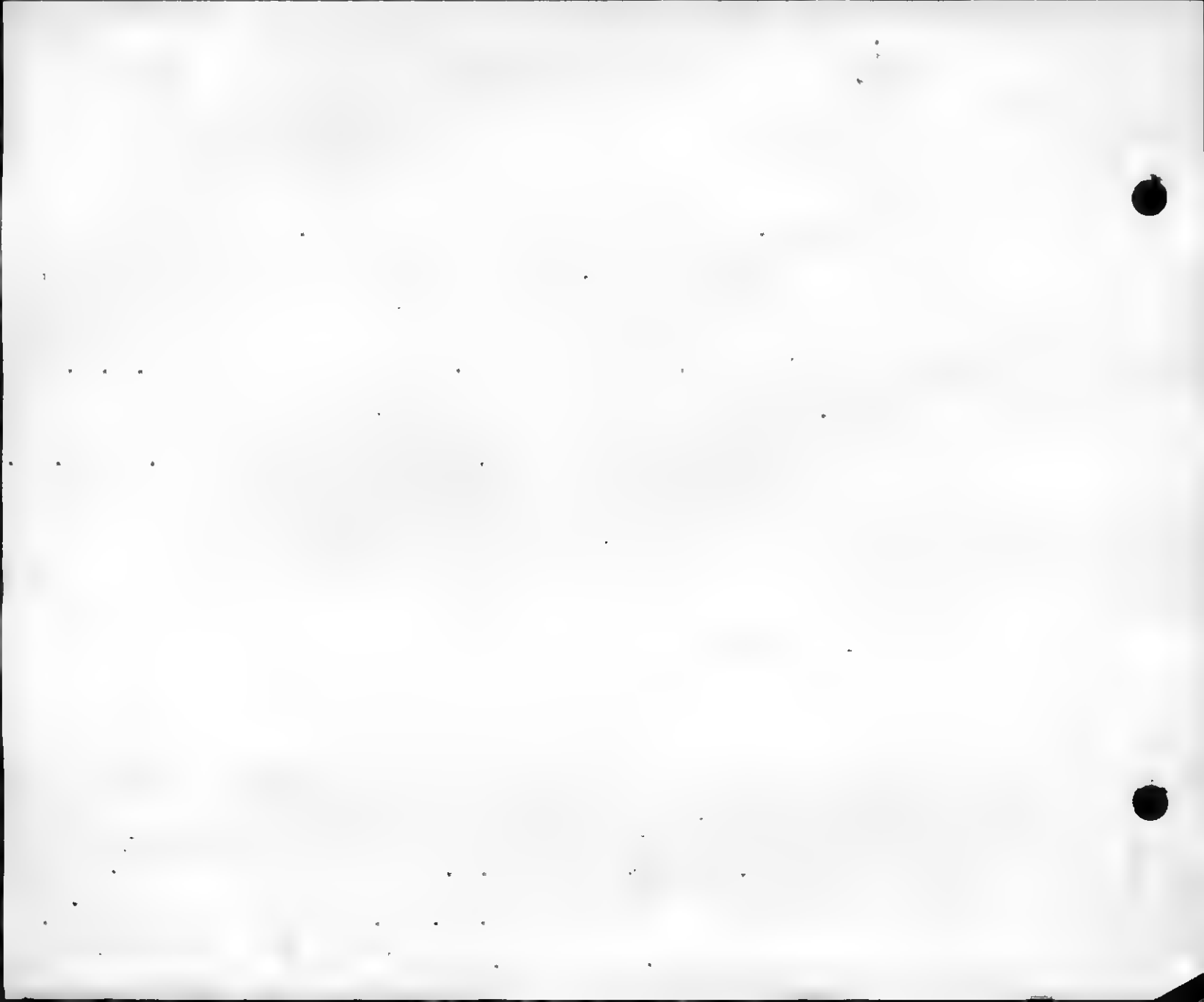
04854

04854

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jones Creek</b>		c. LENGTH OF STAY IN Tb <b>21219</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jones Creek</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7300 Geise Ave.</b>				d. STREET ADDRESS <b>7300 Geise Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>R.</b> Last <b>Patton</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/20</b>		9. AGE (In years last birthday) <b>46</b>		10. IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min <b>46</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper on Truck</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Kelly Gregory Inc.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles A. Patton</b>				14. MOTHER'S MAIDEN NAME <b>Freda Laubach</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-9324</b>		17. INFORMANT (Mother) <b>Mrs. Freda Reed</b>		Address <b>7300 Geise Ave. Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per part. Death was caused by IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HC VD</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Exogenous obesity</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)					
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Theodore C. Patterson</b>		M.D. <b>Theodore C. Patterson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>21222 4/28/67</b>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b>		M.D. Address (Street, city, town or county) <b>105 Main St. Dundalk</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Pk. Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Liberty Road, Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a. REC'D BY REG. STRAR <b>MAY 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

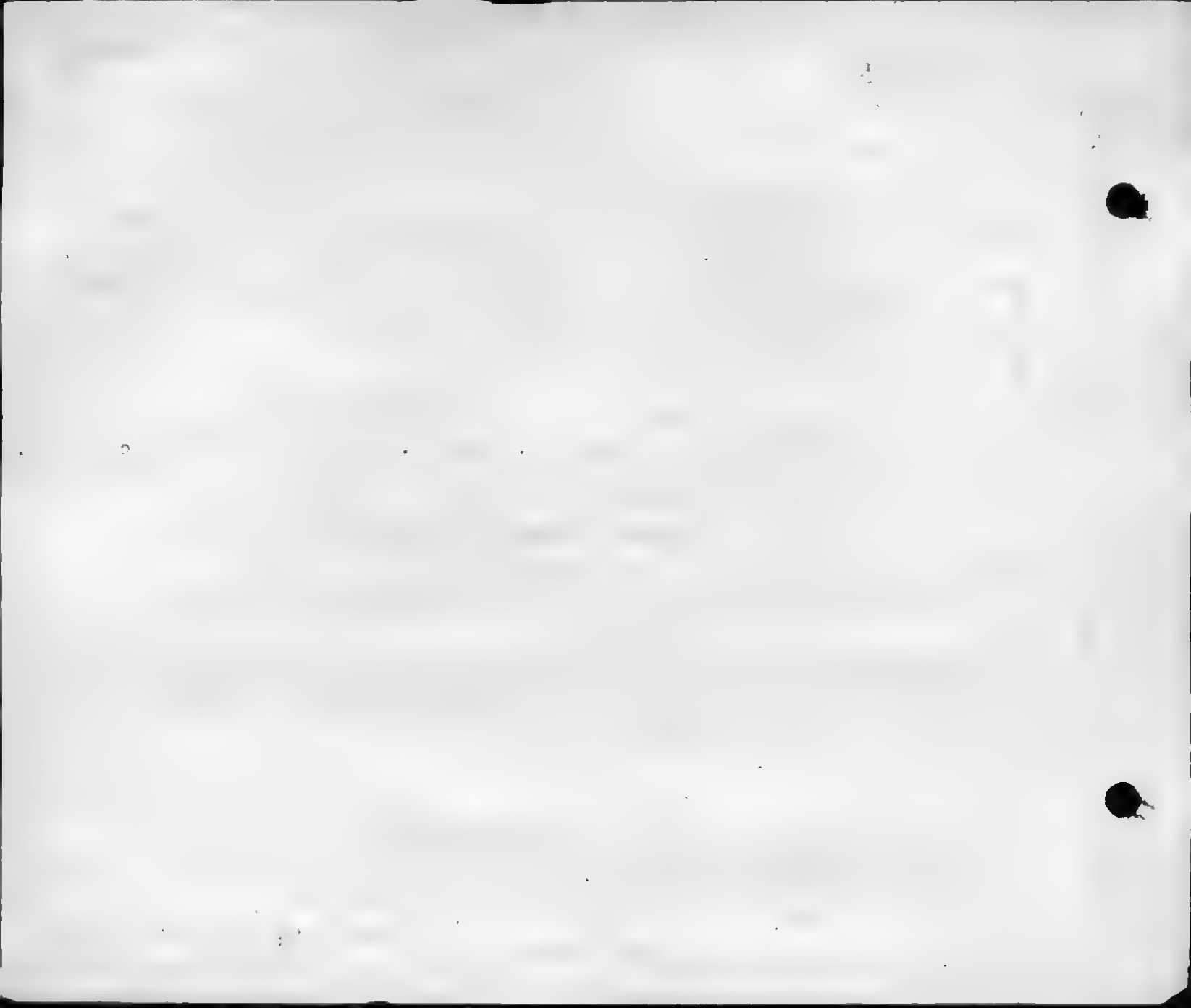
## CERTIFICATE OF DEATH

04855

04855

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN b. <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Stella Maris Hospital</b>		e. STATE <b>Maryland</b>		f. COUNTY <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Isabelle Wilson Perkins</b>		4. DATE OF DEATH Month <b>Apr</b> Day <b>15</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>June 14, 1874</b>		9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR: Months <b>1</b> Days <b>15</b> IF UNDER 24 HRS.: Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Missouri</b>		13. FATHER'S NAME <b>Alexander Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Woods</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-7149 D</b>		17. INFORMANT <b>Mr. Arthur W. Perkins</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Regurgitant Arrest</b> DUE TO <b>Coronary Heart Failure</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>ASCD</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ASCD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2-28-67</b> , <b>1967</b> , to <b>4-15</b> , <b>1967</b> , that (I) (we) last saw the deceased alive on <b>4/14</b> , <b>1967</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert J. Maloney</b>		22b. DATE SIGNED <b>APR 17 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert T. Mithon</b>	
22d. ADDRESS <b>204 E. Jappa Rd. Towson</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/17/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23d. LOCATION (City, town or county) <b>Baltimore</b>		23e. (State) <b>Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Tichner</b>		24a. ADDRESS <b>Baltimore</b>		24b. PHONE NO. <b>761-1100</b>	
25a. RECORD REGISTRAR <b>APR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

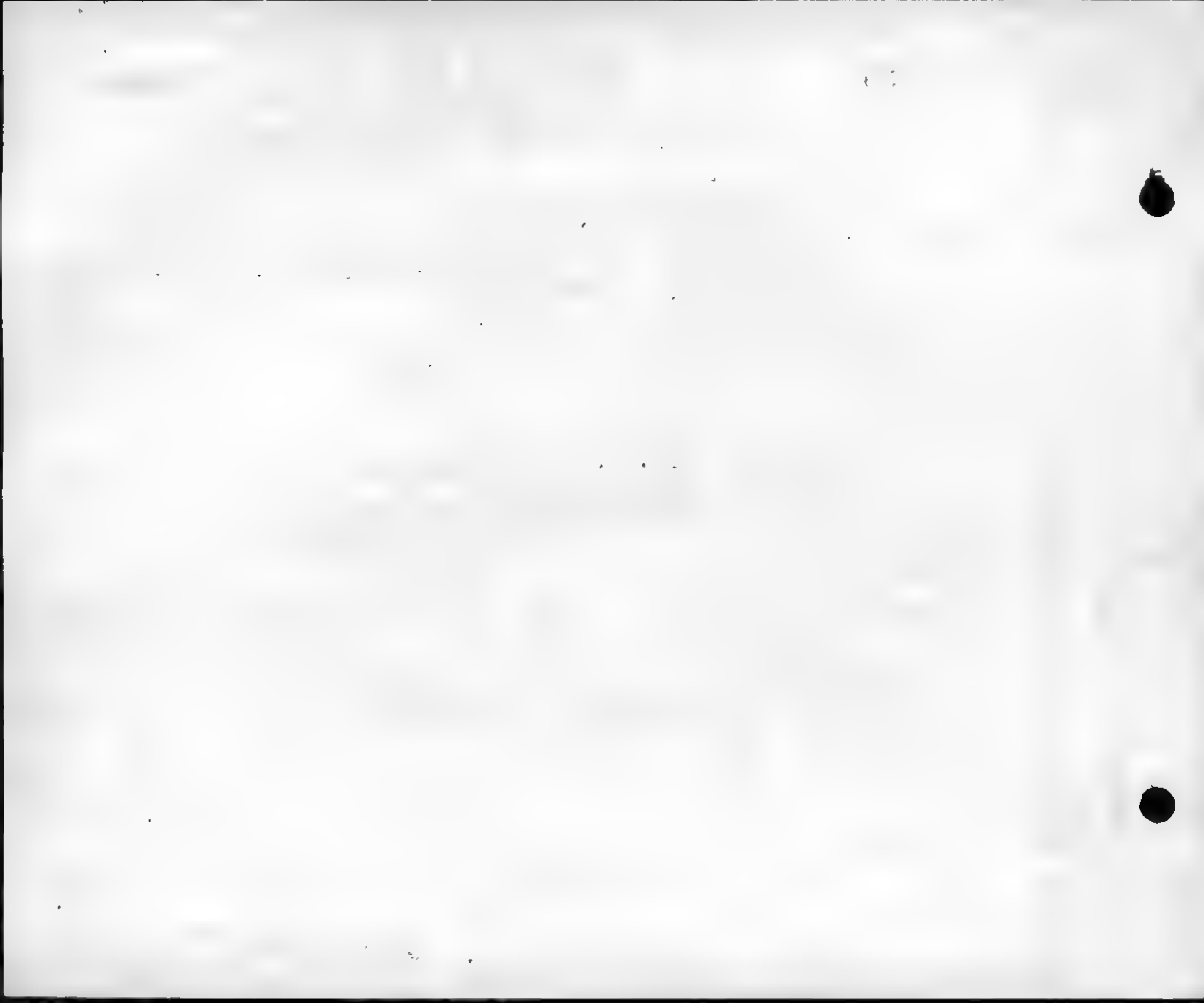
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04856

CERTIFICATE OF DEATH

04856

1 PLACE OF DEATH a. COUNTY <u>Bolb. County Md.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Bolb. County Md.</u> b. COUNTY <u>Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bolb. County General Hosp.</u>		e. STREET ADDRESS <u>2108 Quynmole Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>Hickman</u>		4 DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. AGE (in years and months) <u>64</u> yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	13 FATHER'S NAME <u>William Fitcher</u>	14 MOTHER'S MARDEN NAME <u>Bushman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>220.30.0242</u>	17 INFORMANT <u>Chert</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Multiple embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CA of many with metastases</u> DUE TO (c) <u>Arteriosclerosis secondary to above</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6-8 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-17, 1967</u> , to <u>4-17, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-30-1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. J. T. Stansbury</u>	M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. T. Stansbury</u>	22d. ADDRESS <u>B.C.G. H.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>J.T. Stansbury 6411 Windsor Mill Rd.</u>		25a. APR BY REGISTRAR <u>APR 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04857

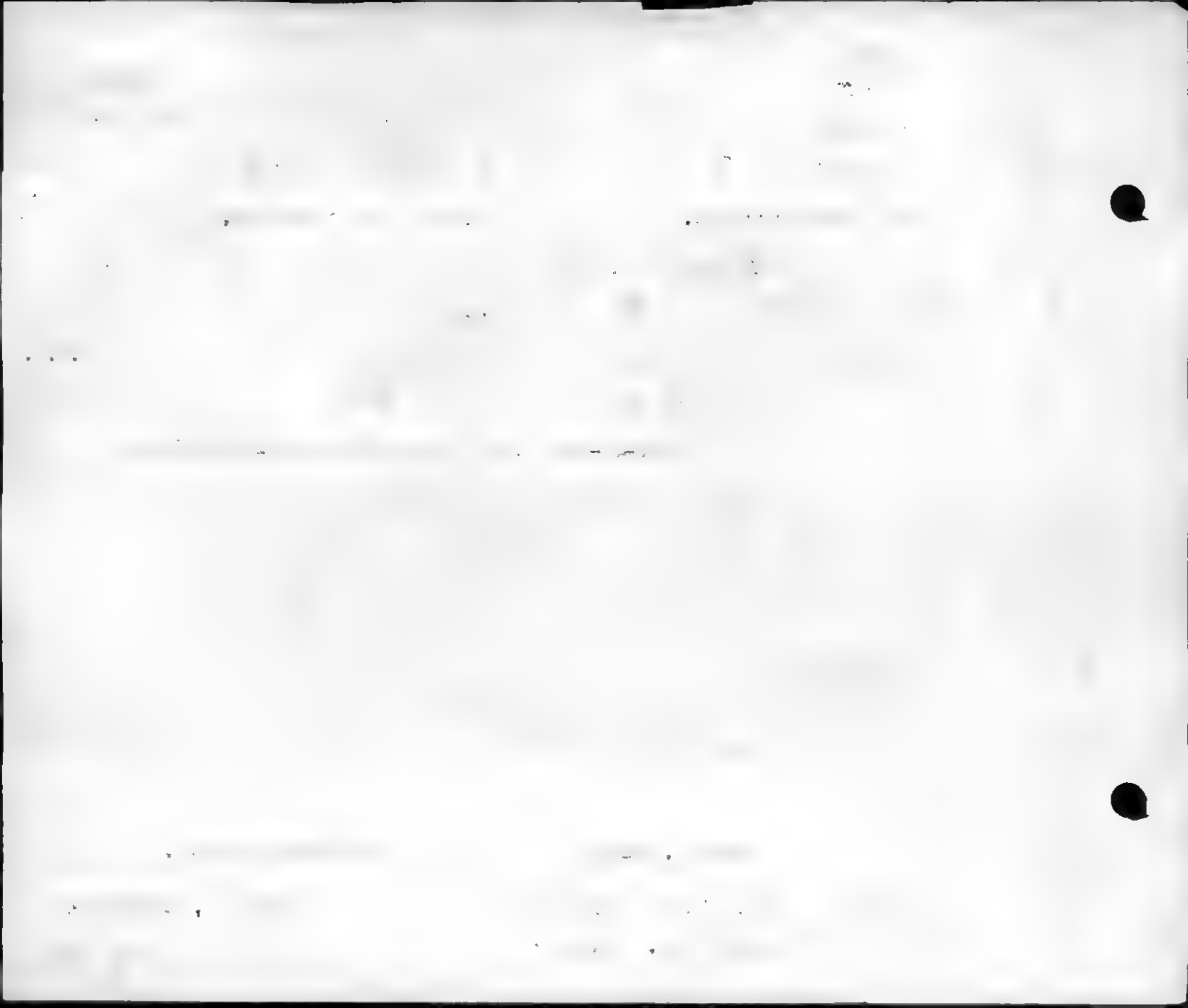
CERTIFICATE OF DEATH

04857

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN b <b>28</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21228</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1216 Black Friars Rd.</b>		d. STREET ADDRESS <b>1216 Black Friars Rd.</b>	
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Pfaff</b> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 31, 1880</b>
9 AGE (In years last birthday) <b>86</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pfaff</b>		14. MOTHER'S MAIDEN NAME <b>Katie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service]		16. SOCIAL SECURITY NO. <b>220-44-3489</b>	
17. INFORMANT <b>Mrs Joan Grelli</b>		Address <b>1216 Black Friars Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arterio-sclerotic cardio Vase Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 11, 1967</b> to <b>Apr. 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Apr. 13, 1967</b> , and that death occurred at <b>3:01 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Harry L. Knipp</b>		22b. DATE SIGNED <b>4-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry L. Knipp</b>		22d. ADDRESS <b>4116 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 17, 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>	23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hwy. Glenburnie</b>
24. FUNERAL DIRECTOR <b>Witzke 4101 Edmondson Ave. Baltimore</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



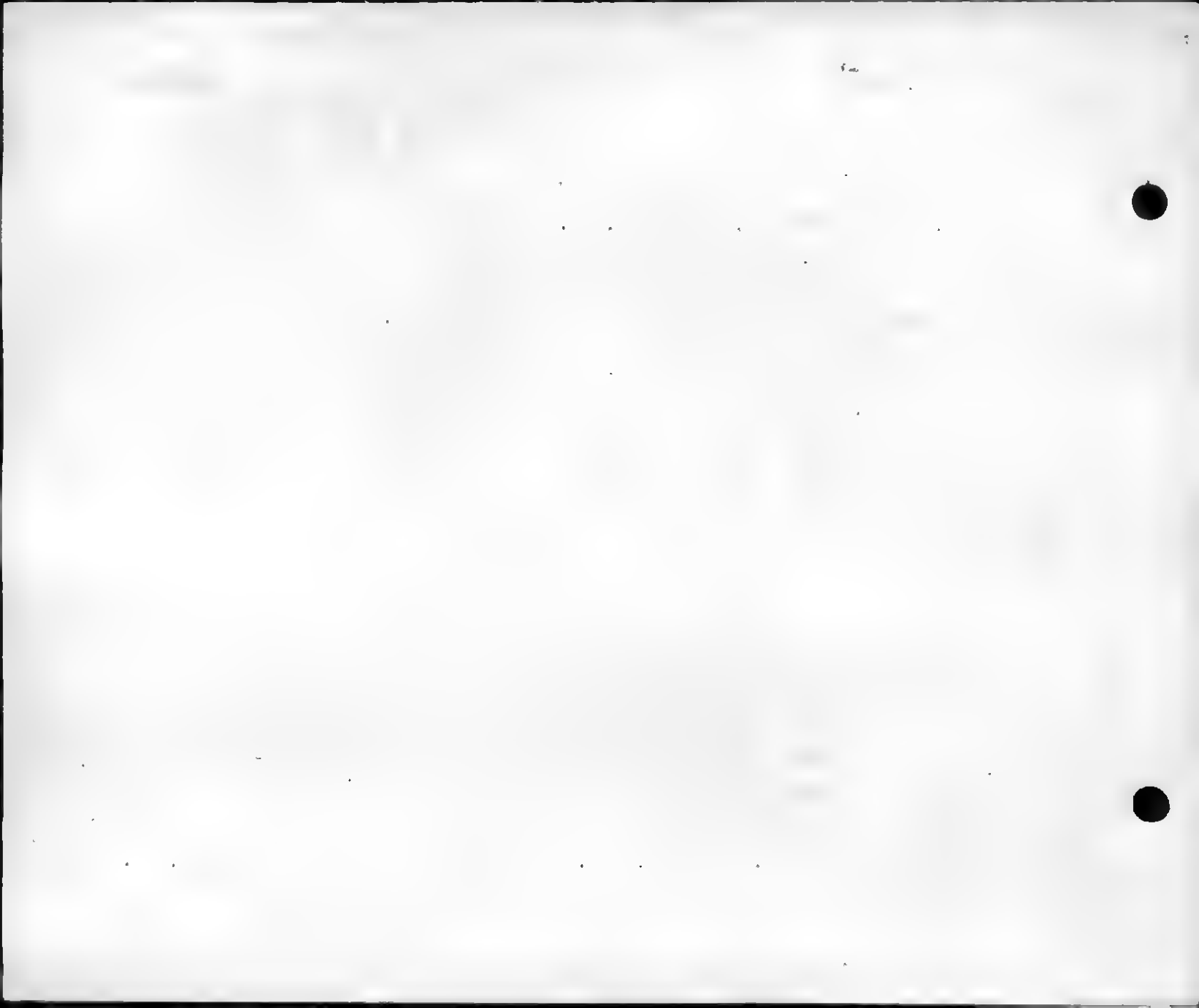
04858

CERTIFICATE OF DEATH

04858

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>16 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, Baltimore, Md. 21204</b>		d. STREET ADDRESS <b>9442 Belair Road, 21206</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DEBORAH BABY MARIE OLIVE POIST</b>		4. DATE OF DEATH Month Day Year <b>April 16 1967</b>	
5 SEX <b>Female</b>	6 CO. OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 15, 1967</b>
9 AGE (In years last birthday) yrs <b>16</b>		IF UNDER 1 YEAR Months Days <b>16</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Ralph Bernard Poist</b>		14. MOTHER'S MAIDEN NAME <b>Deborah Ann Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>	
17 INFORMANT <b>Parents</b>		Address <b>same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>772.5</b> DUE TO <b>(Cause of death determined)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Immunodeficiency of the lungs</b> (c) <b>Immunodeficiency of the lungs</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>4-15</b> , 19 <b>67</b> , to <b>4-16</b> , 19 <b>67</b> , that (X) (we) lost saw the deceased alive on <b>4-16</b> , 19 <b>67</b> , and that death occurred at <b>7:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Juana S. Cockburn</b> M.D.		22b. DATE SIGNED <b>4-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Juana S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Md</b>
24 FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>		25a REC'D BY REGISTRAR <b>APR 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

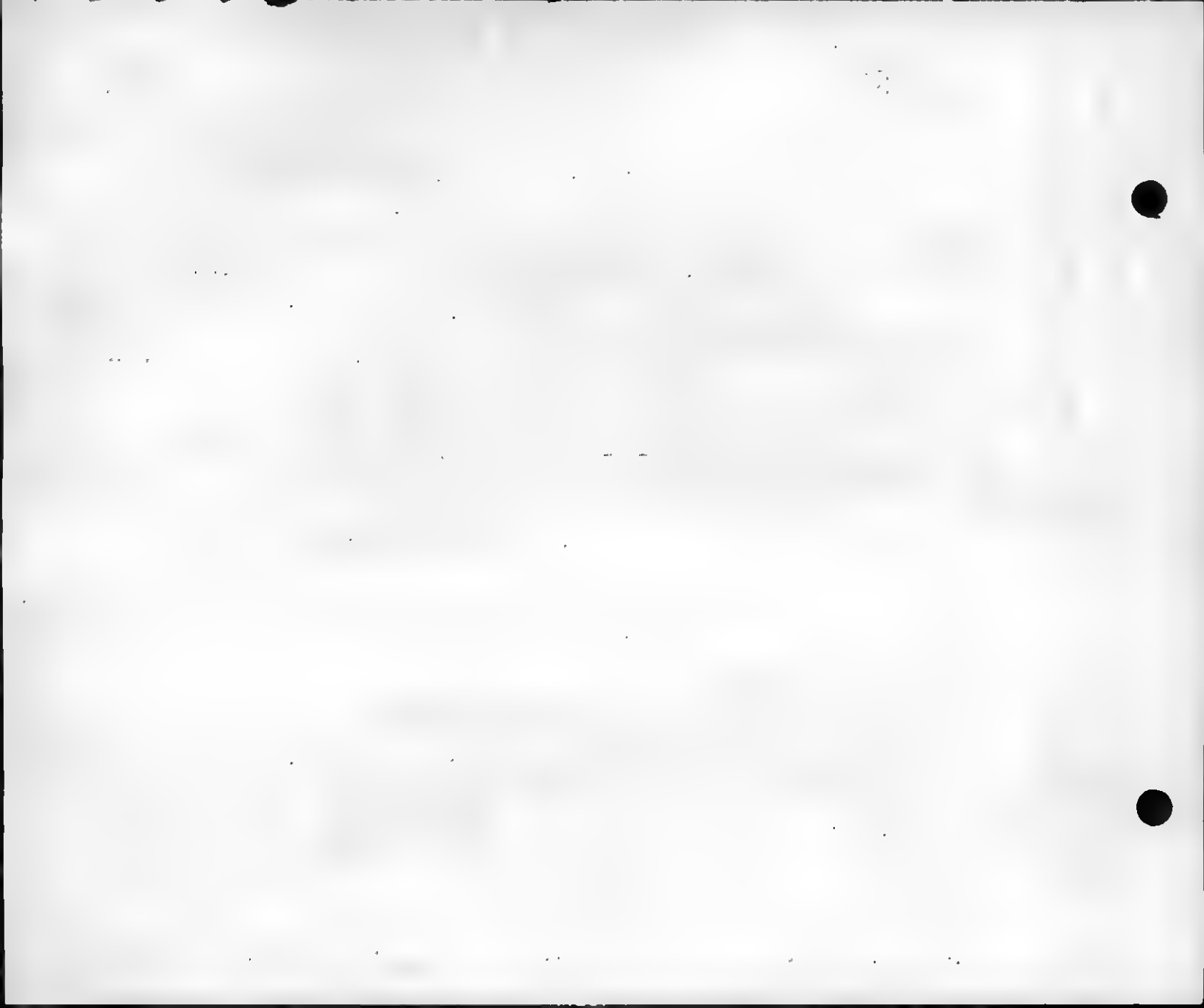


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04853 CERTIFICATE OF DEATH 04859

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN ID <b>2mth 9dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Katherine</b> Last <b>Pole</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1898</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Spittel</b>		14. MOTHER'S MAIDEN NAME <b>Anna Steuben</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-01-4368</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>GENERAL ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONIA</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Jan. 13</b> , 19 <b>67</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Vicente M. Ruelas</b>		22b. DATE SIGNED <b>4-8-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICENTE M. RUAYU</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-11-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04860

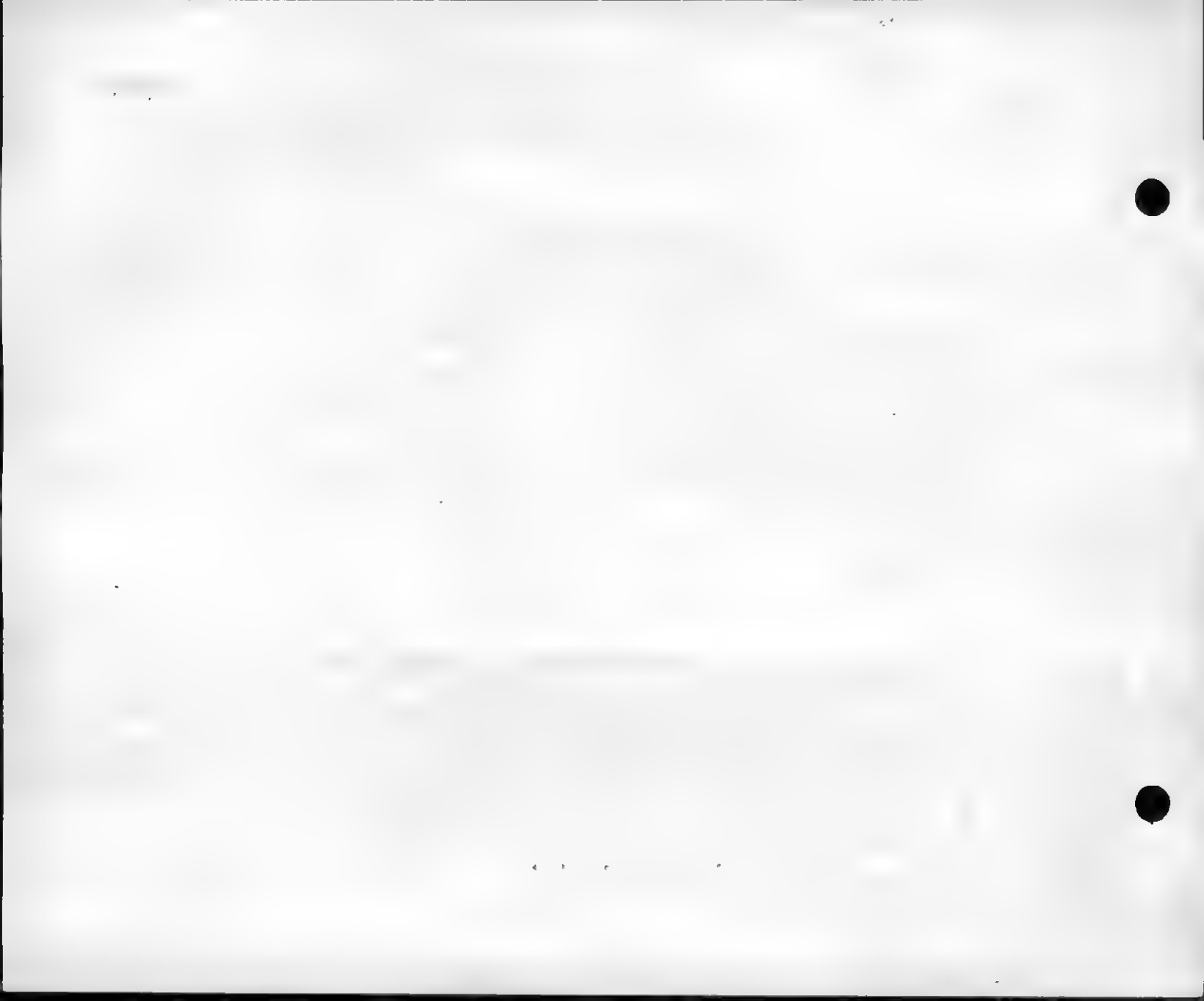
**CERTIFICATE OF DEATH**

04860

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>Oakland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> <sup>First</sup> <u>Oflutt</u> <sup>Middle</sup> <u>Polk</u> <sup>Last</sup>		4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 20, 1886</u>
9. AGE (In years last birthday) yrs <u>80</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel E. Oflutt</u>		14. MOTHER'S MAIDEN NAME <u>Anabella Seymour</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>220-48-4052</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4121 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>ASCLN</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>66</u> , to <u>May</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>67</u> , and that death occurred at <u>2 p</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>RK Gundry</u>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard K. Gundry, M.D.</u>		22d. ADDRESS <u>2 West University, 21218</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Burial April 18, 1967</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Oakland, Maryland</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

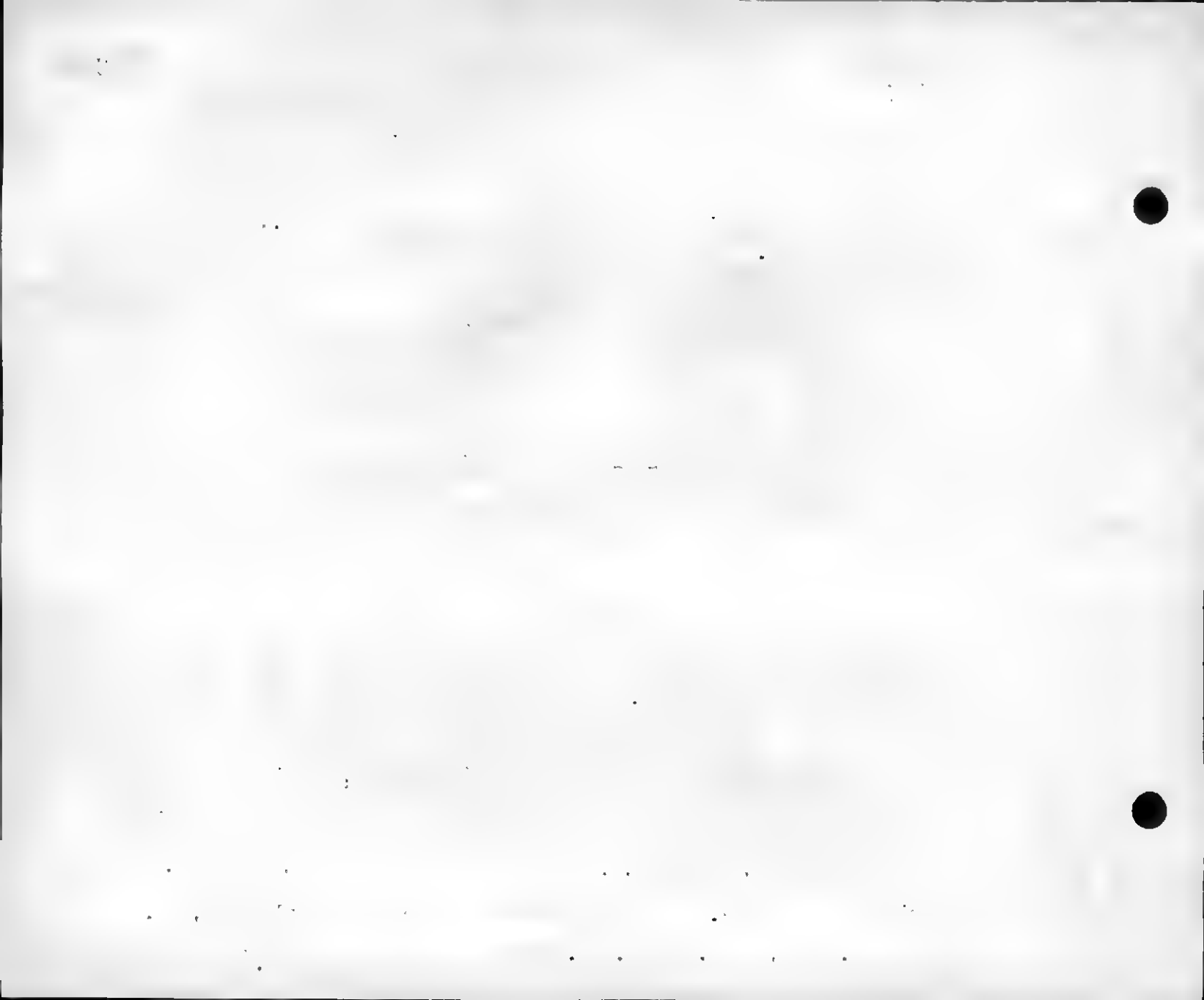
04861

CERTIFICATE OF DEATH

04861

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 yr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stella Maris Hospice</b>				d. STREET ADDRESS <b>4301 Roland Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>E. First Middle Last Fannie Pottgiesser</b>				4. DATE OF DEATH <b>4 / 17 / 67</b> 19 <b>19</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/1880</b>		9. AGE (In years last birthday) <b>86</b> yrs	10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Pottgiesser</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Sweitzer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-09-3195</b>		17. INFORMANT <b>Hospice records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5704</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>G.I. Tract Bleeding, Cause Not Determined</b> DUE TO <b>Ascites</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/30/66</b> , 19 <b>19</b> , to <b>4/17/67</b> , 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>4/15/67</b> , 19 <b>19</b> , and that death occurred at <b>6:01 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Robert J. Mahon</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>				22d. ADDRESS <b>201 E. Joppa Rd.,</b>			
23a. BURIAL, CREMATION, REINTERMENT (County)		23b. DATE THEREOF <b>4/21/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>APR 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04862

CERTIFICATE OF DEATH

04862

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY in 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Randallstown</u>		21133	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>				d. STREET ADDRESS <u>Box 361X Marriottsville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Calvin</u> Last <u>Powell</u>				4 DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-92</u>	9 AGE (in years last birthday) <u>75</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawmower Bus</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>James Powell</u>				14 MOTHER'S MAIDEN NAME <u>Martha DeVall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>217-12-8561</u>		17 INFORMANT <u>Hosp. Record</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic oropharyngeal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Direct myocardium, chronic fat emboli</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-4-1967</u> , to <u>4-17-1967</u> , that (I) (we) last saw the deceased alive on <u>4-17-1967</u> , and that death occurred at <u>2:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward L. Sherres, MD</u>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>17 Apr 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward L. Sherres, MD</u>				22d. ADDRESS <u>Balto Co. Gen Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		23d. LOCATION (City or Town) (County) (State) <u>Int Airy Carroll Md</u>	
24. FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road Randallstown Md</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



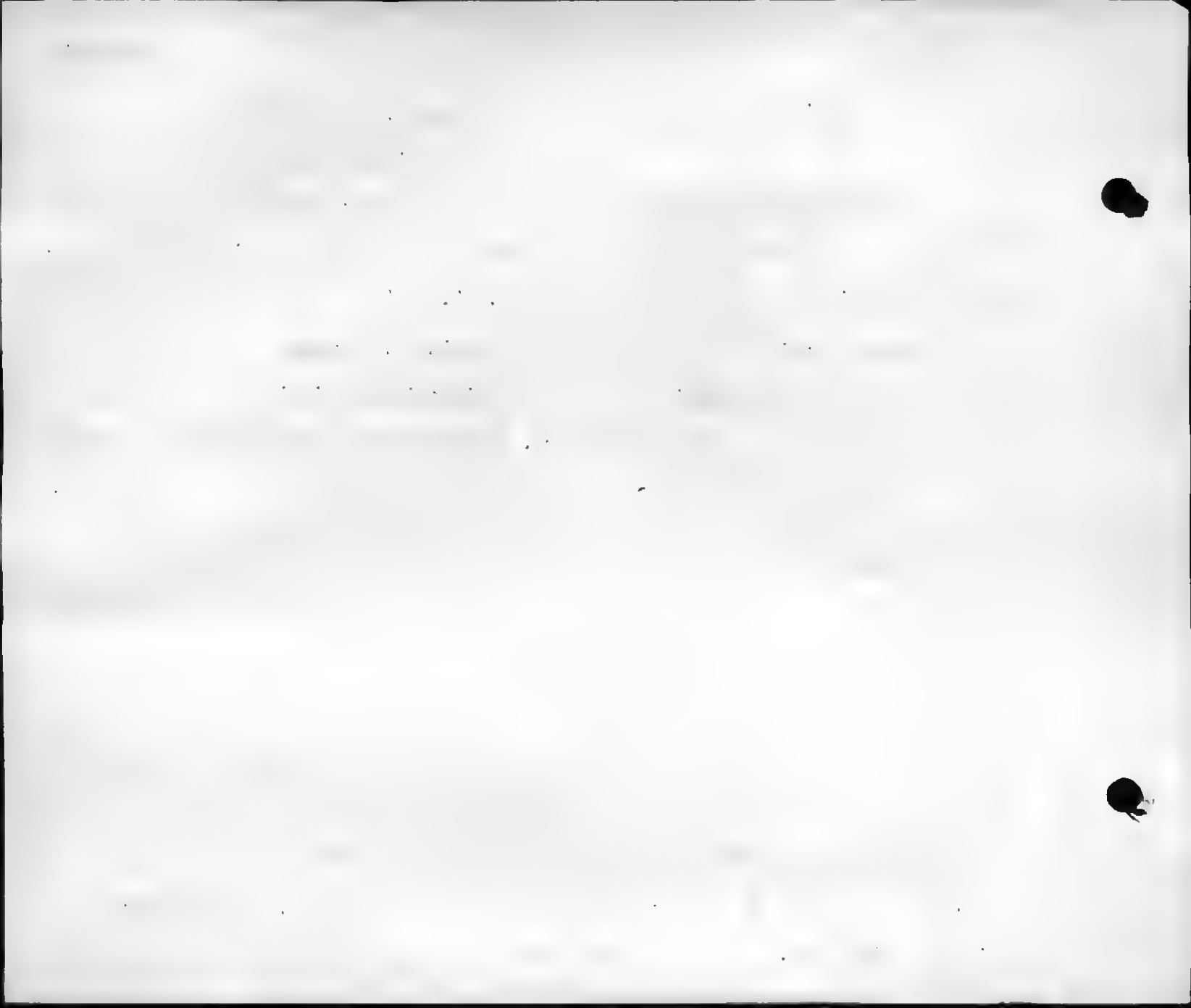
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04863

04863

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore County</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7038 Eastbrook Avenue</b>				d. STREET ADDRESS <b>7038 Eastbrook Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle Last <b>POWELL</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1917</b>		9. AGE (In years last birthday) <b>49</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Body &amp; Fender Repair</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Walter Przybylowski</b>				14. MOTHER'S MAIDEN NAME <b>Michalina Ludwicki</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-3171</b>		17. INFORMANT Address <b>Mrs. Margaret Powell 7038 Eastbrook Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15/66</u> 19, to <u>4/21/67</u> 19, that (I) (we) last saw the deceased alive on <u>4/19/67</u> 19, and that death occurred on <u>4/21/67</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Max Baum</i>				22b. DATE SIGNED <b>4/22/67</b>		22c. PHYSICIAN'S NAME (Type) <b>MAX BAUM</b>	
22d. ADDRESS <b>7422 EASTERN AVE - BALTO., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-24-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Avenue</b>				25a. REC'D BY REGISTRAR DATE <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

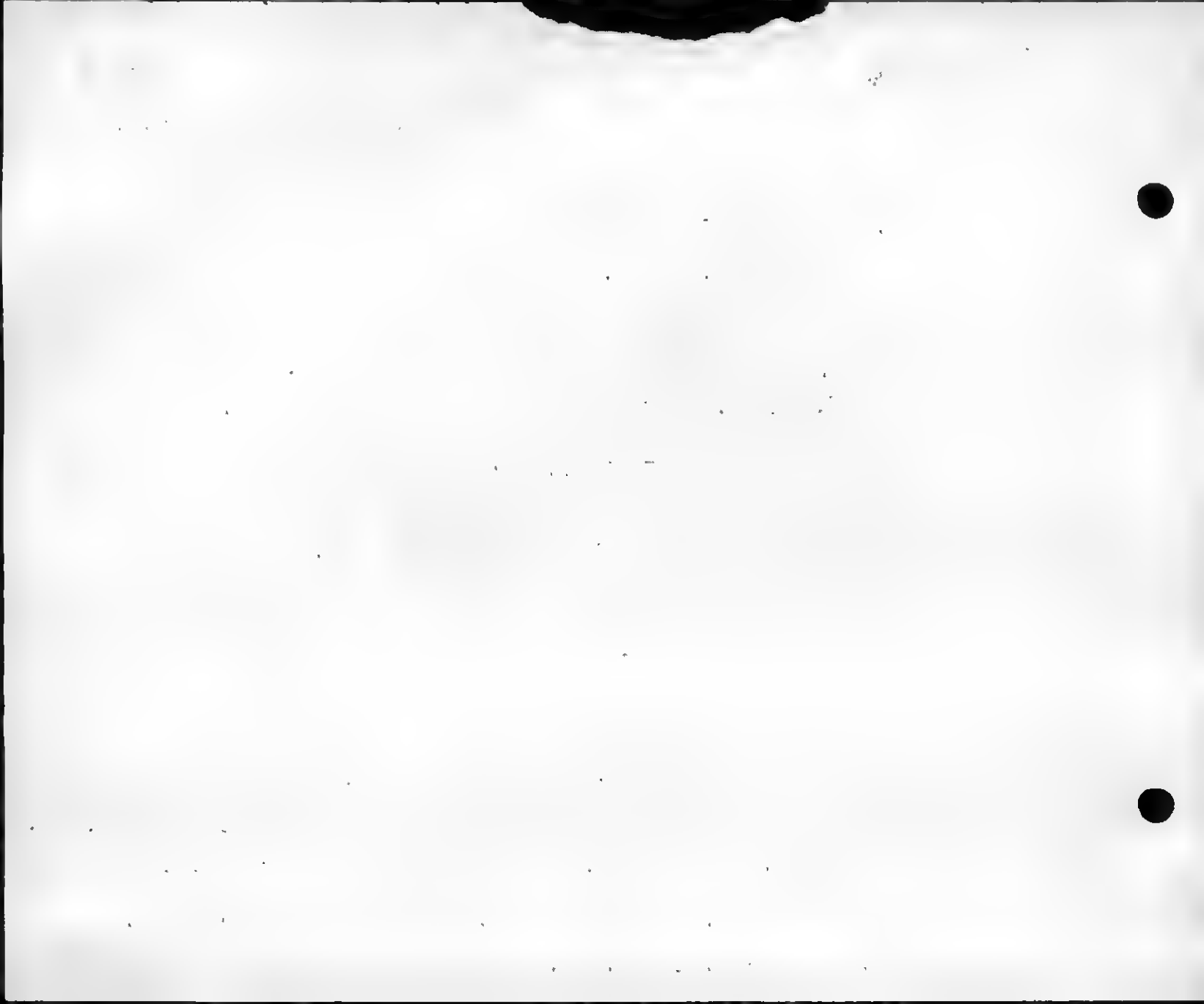
04864

**CERTIFICATE OF DEATH**

04864

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>21204</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>524 Epson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>L.</b> Last <b>Priestas</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-21-17</b>	9. AGE (In years lost birthday) yrs <b>49</b>	f. UNDER 1 YEAR Months <b>03</b> Days <b>03</b> Hours <b>03</b> Min. <b>03</b>		IF UNDER 24 HRS Months <b>03</b> Days <b>03</b> Hours <b>03</b> Min. <b>03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State or foreign country) <b>Cambridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William B. Burton</b>				14. MOTHER'S MAIDEN NAME <b>Mary M. Saulsbury</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>168-16-8294</b>		17. INFORMANT <b>Mr. Edward Priestas</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bleeding esophageal varices.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced cirrhosis of the liver.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Cholecystectomy 10 days ago.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>April 7</b> , 19 <b>67</b> , to <b>April 26</b> , 19 <b>67</b> , that <b>Dr.</b> (we) last saw the deceased alive on <b>April 26</b> , 19 <b>67</b> , and that death occurred at <b>12:15 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Juana S. Cockburn</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 26, 1967.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Juana S. Cockburn, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/29/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Cemetery Baltimore, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>APR 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04865

CERTIFICATE OF DEATH

04865

1 PLACE OF DEATH a COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1017 VANDERWOOD RD.</u>		d. STREET ADDRESS <u>1017 VANDERWOOD RD.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES H. PRZYBYLA</u>		4 DATE OF DEATH Month Day Year <u>APRIL 27 1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/10</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) <u>MASS.</u>
13 FATHER'S NAME <u>JOSEPH MIRTOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>HELEN SKWISZ</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	17 INFORMANT Address <u>JOAN A PRZYBYLA</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast - Metastasis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1964 to <u>4/27</u> , 1967 that (I) ( <u>we</u> ) last saw the deceased alive on <u>4/24</u> 1967, and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James Nolan</u>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J S NOLAN</u>		22d. ADDRESS <u>Baltimore Md 21229</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>5/1/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW</u>	23d LOCATION (City or Town) (County) (State) <u>CARROLL CO. MD.</u>
24. FUNERAL DIRECTOR <u>E. S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>301 FREDERICK RD 21228</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

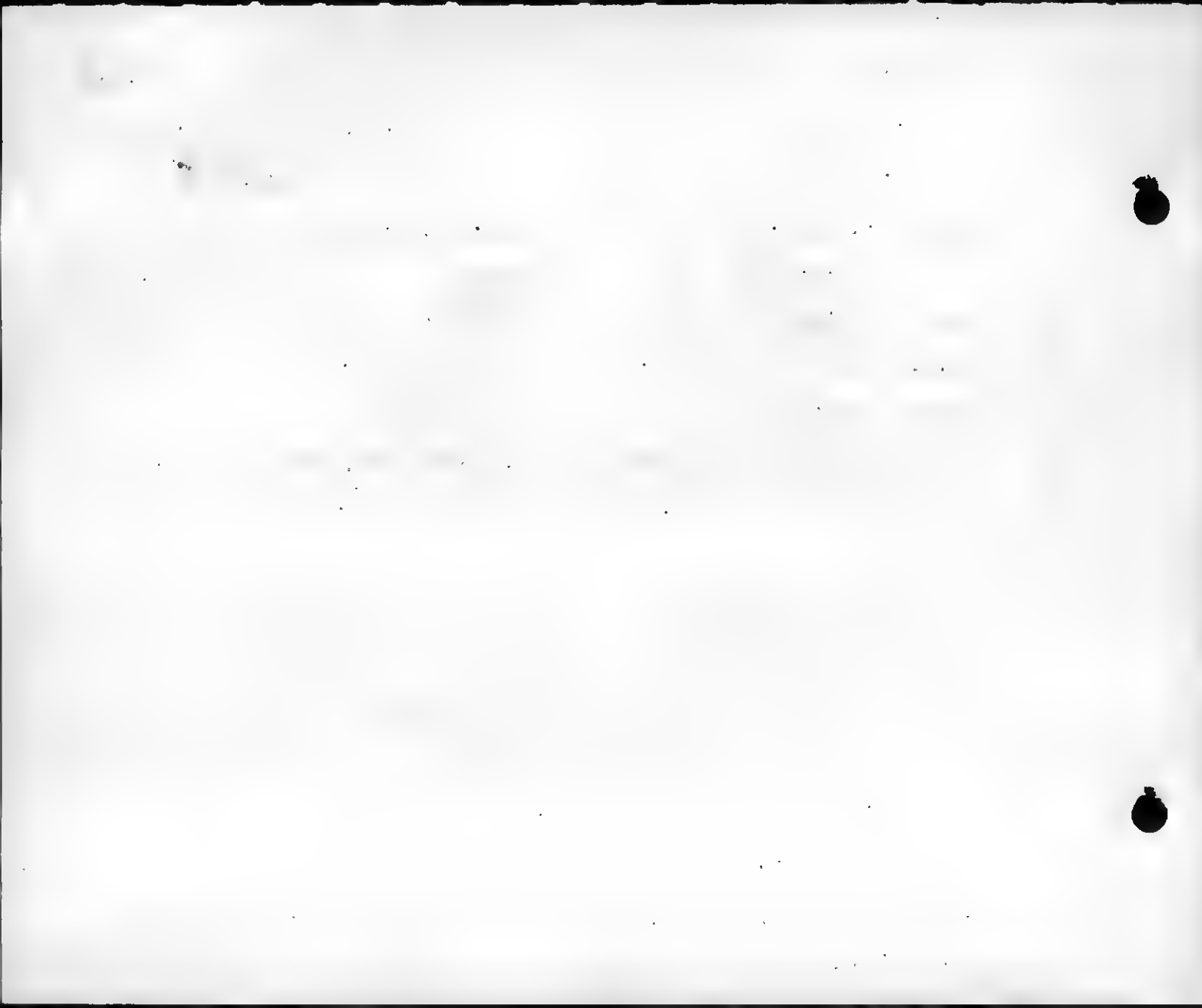
FOR STATE  
HEALTH DEPT.

04866

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04866

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6816 Duluth Avenue</b>		e. STREET ADDRESS <b>6816 Duluth Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Alex J Puscian</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>197</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>II-7-1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitation Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore County</b>	9. AGE (In years last birthday) <b>59</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Felixx Puscian</b>		14. MOTHER'S MAIDEN NAME <b>A nna Ollies</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-8000</b>	
17. INFORMANT <b>Mrs Clara Puscian</b>		Address <b>6816 Duluth Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <b>Coronary Occlusion</b> DUE TO (c) <b>A-S-C-V-Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No one</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. Davis M.D. - Dundalk</b>		22. DATE SIGNED <b>4/22/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Stanislaus Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Dabrowski</b>		ADDRESS <b>1005 Dundalk Avenue</b>	
25a. REC'D BY REGISTRAR <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

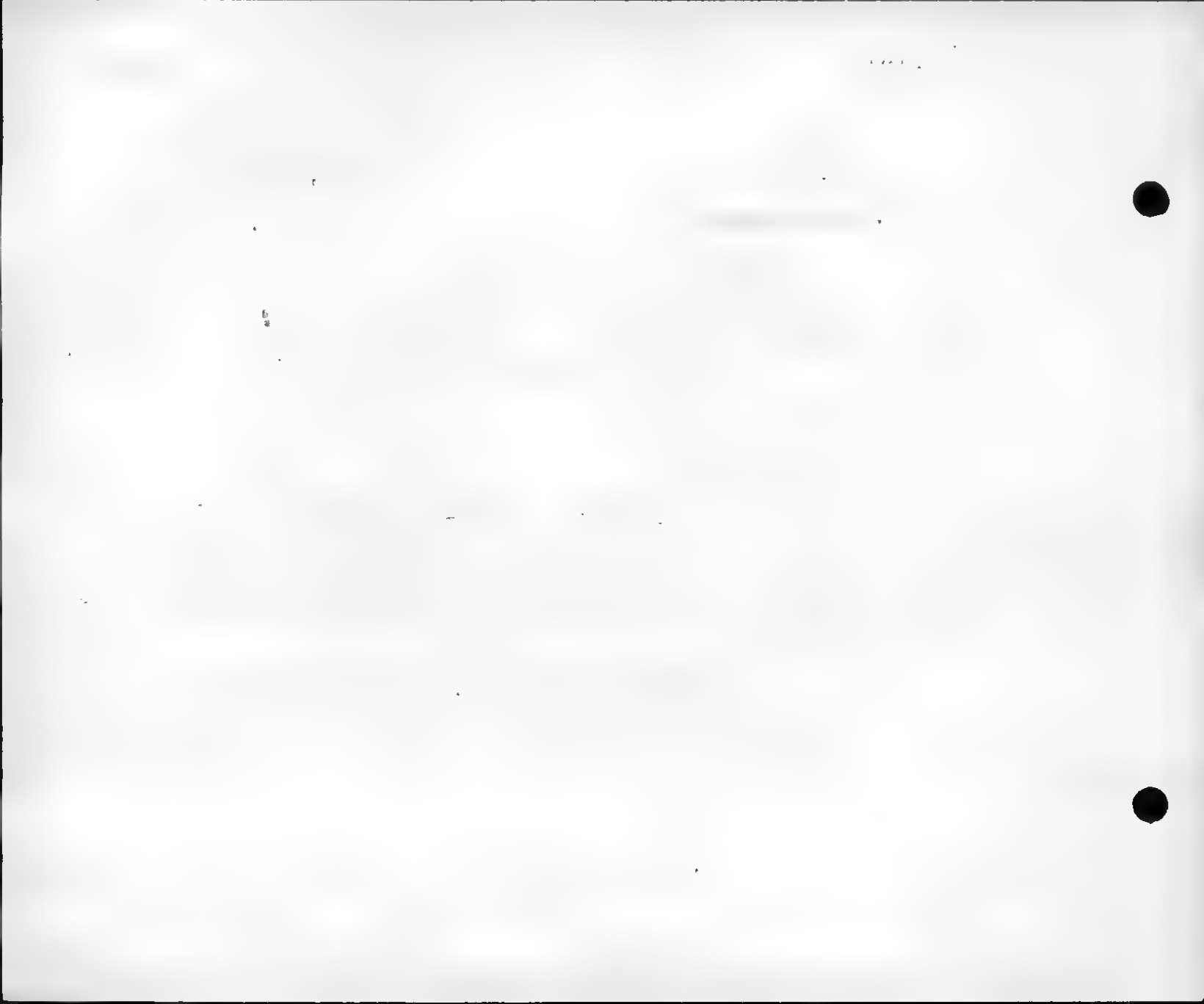
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04867

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if instit. or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWNS ON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>2208 Wilker Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sophia</b> Middle <b>C.</b> Last <b>Quatman</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/13/1875</b>
9. AGE (in years last birthday) <b>91</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>1</b> Hours <b>1</b> Mins. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY HAMEL</b>		14. MOTHER'S MAIDEN NAME <b>Sophia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>HENRY QUATMAN</b>	
17. INFORMANT <b>HENRY QUATMAN</b>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Fracture Left Femur of Pelvis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 Days</b> <b>12 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell on Bed</b>	
20c. TIME OF INJURY Month/Day/Year Hour a.m. <b>April 7 1967</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work or work	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY OR TOWN (County) (State) <b>Baltimore</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>	23d. LOCATION (city or town) (County) (State) <b>BALTO. MARYLAND</b>
24. FUNERAL DIRECTOR <b>C.F. Gorman</b>		25a. RECEIVED BY REGISTRAR <b>APR 21 1967</b>	
ADDRESS <b>8802 NORTON RD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



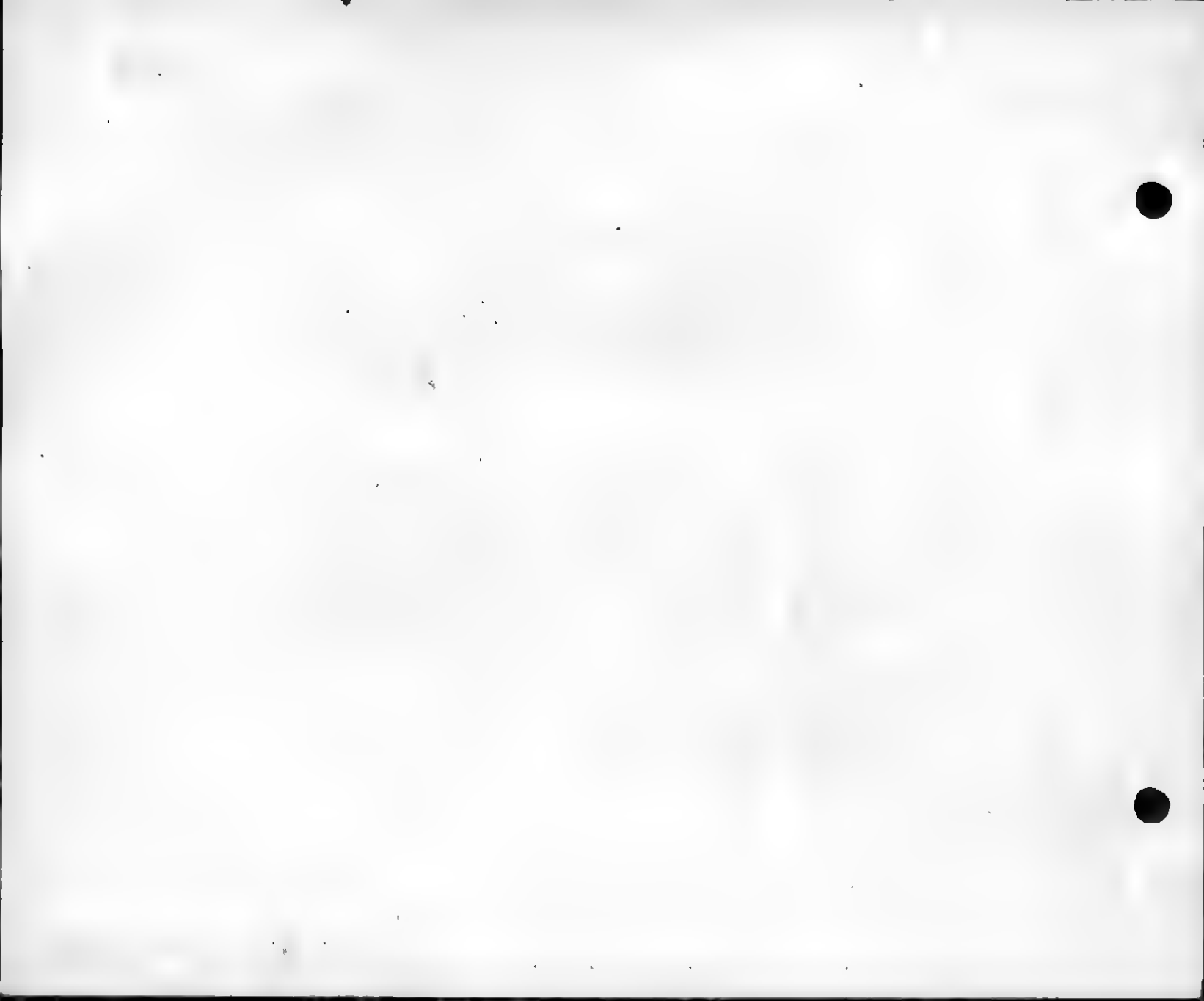


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04868 CERTIFICATE OF DEATH 04868									
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>					d. STREET ADDRESS <u>1781 Joan Avenue</u>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Randall</u> Middle <u>Randall</u> Last					4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/1903</u>		9. AGE (In years last birthday) <u>64</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Terzano</u>					14. MOTHER'S MAIDEN NAME <u>Carmella Perella</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>219010154</u>		17. INFORMANT Address <u>Mrs. Gloria Culotta, 1626 Myamby Rd.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease, cerebral thrombosis</u> <u>SSA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3 Feb</u> , 19 <u>66</u> to <u>24 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>24 Feb</u> , 19 <u>67</u> , and that death occurred at <u>11 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>25 Feb 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>					22d. ADDRESS <u>6604 W. 1st St. Balto. (34) Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>					25a. REC'D BY REGISTRAR DATE <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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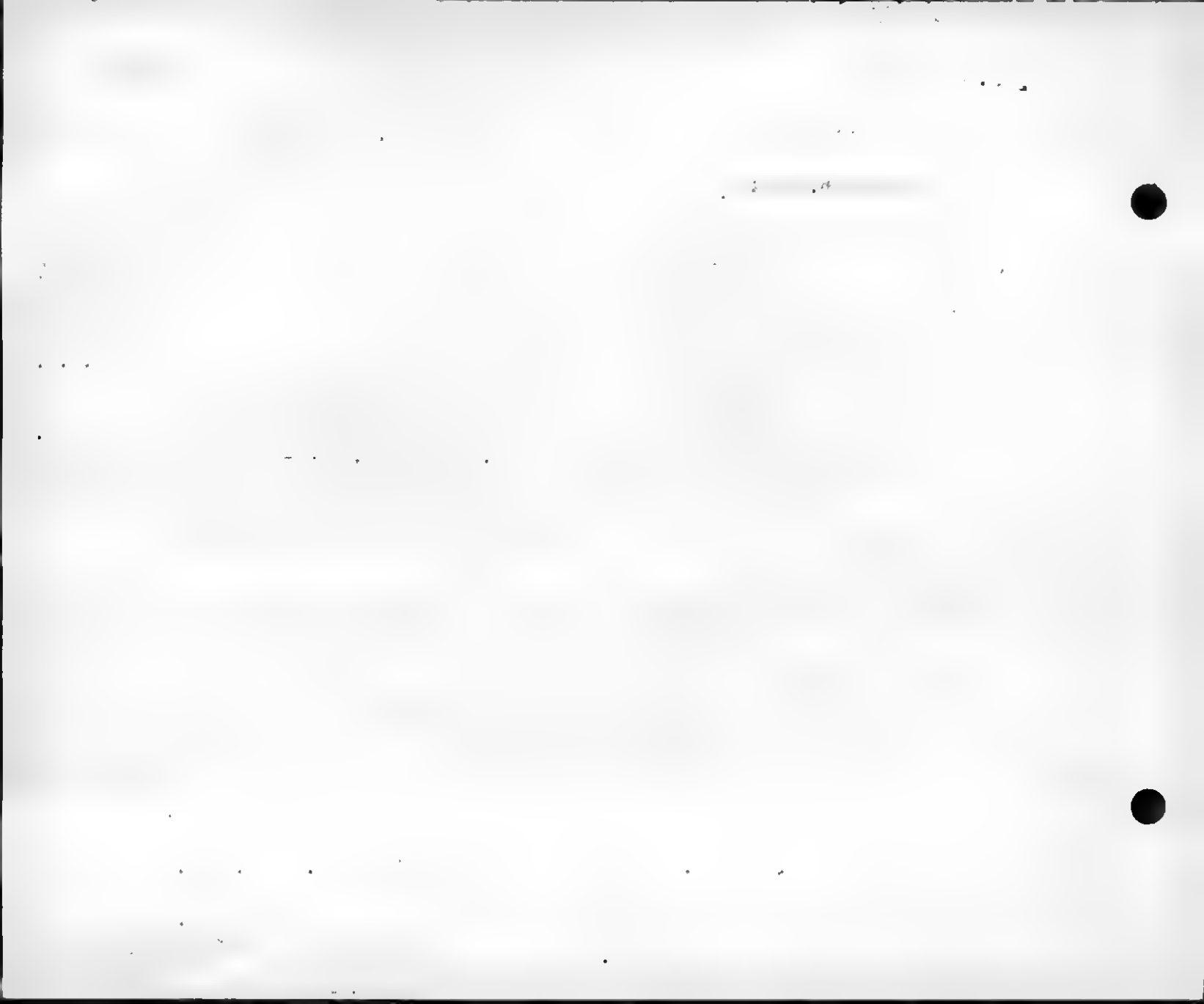
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04863

CERTIFICATE OF DEATH

04869

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Randallstown</b>				c LENGTH OF STAY IN 1b <b>Rural-Woodstock</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>Baltimore County General Hospital</b>				d STREET ADDRESS <b>Grooms Lane</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Michele Margaret Reed</b>				4. DATE OF DEATH Month Day Year <b>April 8 19 67</b>			
5 SEX <b>F</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/17/61</b>	9. AGE (In years last birthday) <b>6</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Balt. City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Conrad Reed</b>				14. MOTHER'S MAIDEN NAME <b>Brunhilde Katherina Stegmann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Md.</b> <b>Mr. Richard C. Reed-Grooms Lane Woodstock</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Demerol</b> DUE TO <b>Intoxication &amp; asphyxiation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>770</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>11:30 P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Fred T. Kyper</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Fred T. Kyper</b>				22d. ADDRESS <b>827 Park Ave. Balt., Md. 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodstock Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodstock, Md. Howard Co.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Loring Byers=8728 Liberty Rd. Randallstown</b>				25a. REC'D BY REGISTRAR DATE <b>APR 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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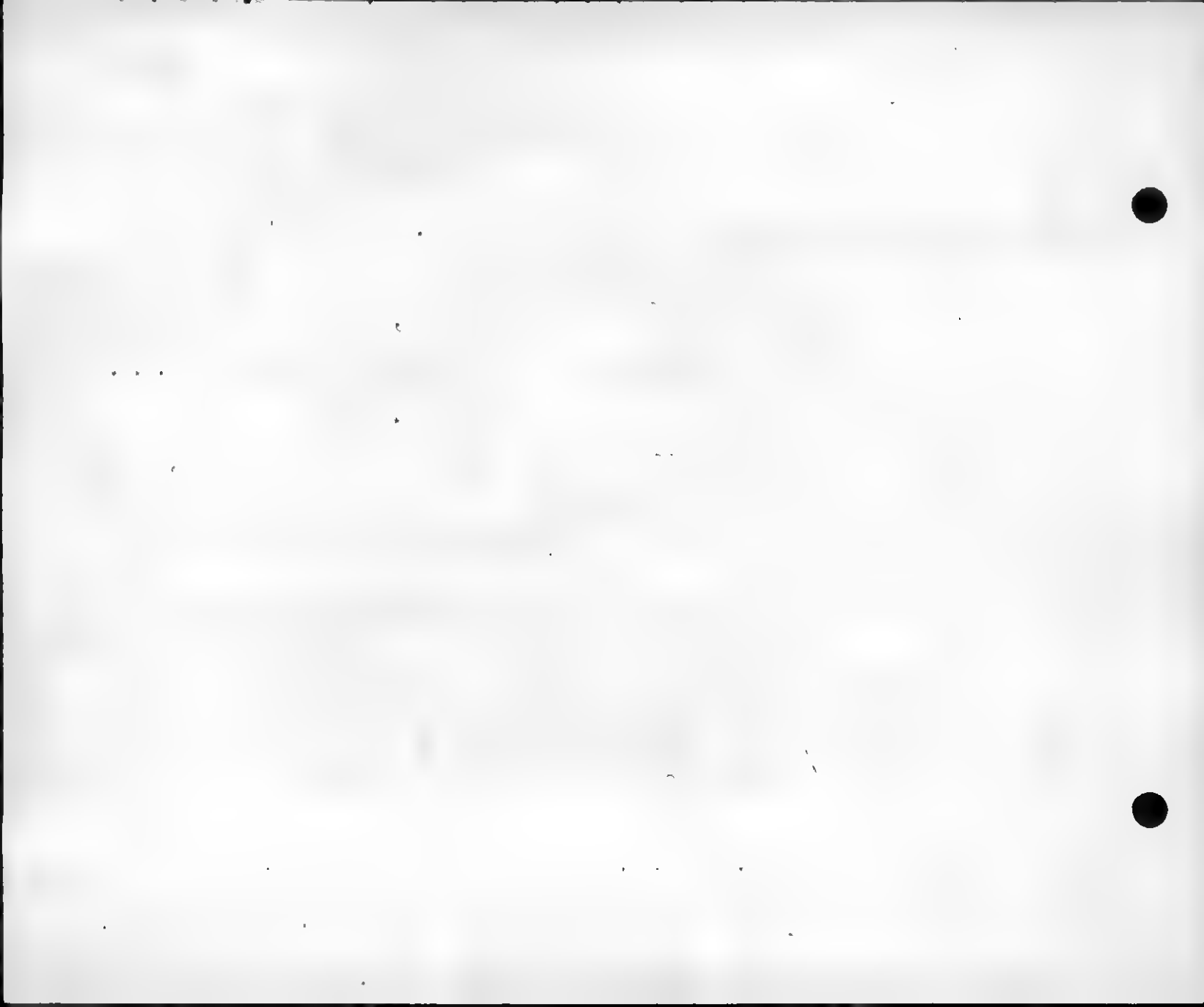
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04870

04870

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN IB <b>5 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. STREET ADDRESS <b>108 E. GREEN STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>RODELL</b> Last <b>REESE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. CO. OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 19, 1922</b>	9. AGE (In years last birthday) <b>44</b> yrs	10. UNDER 1 YEAR Months <b>4</b> Days <b>14</b>	11. UNDER 24 HRS Hours <b>11</b> Min. <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING SHOP</b>		BIRTHPLACE (County & State, or foreign country) <b>NEW WINDSOR, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES REESE</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. SWOPE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>213 18 86 09</b>		17. INFORMANT Address <b>CLINICAL RECORDS FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>28710</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>PORTAL CIRRHOSIS, LIVER WITH NECROSIS AND JAUNDICE</b> UNKNOWN DUE TO (c) <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 28</b> , 1967, to <b>APRIL 2</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 2</b> , 1967, and that death occurred at <b>1115 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				22b. DATE SIGNED <b>4/3/67</b>		22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/6/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BENJAMIN'S REFORMED CHURCH CEM. WESTMINSTER, MD.</b>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <i>James C. Saffell</i>				25a. RECD BY REGISTRAR <b>APR 5 1967</b>		25b. REG STRA'S SIGNATURE <i>James C. Saffell</i>	
25c. ADDRESS <b>SAFFELL FUNERAL HOME MAIN STREET, WESTMINSTER, MD.</b>							



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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																				
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>BALTIMORE</u> <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u> <b>c. LENGTH OF STAY IN 1b</b> <u>21 DAYS</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <u>MD</u> <b>b. COUNTY</b> <u>Balto.</u> <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <b>d. STREET ADDRESS</b> <u>2913 ONYX RD 34</u> <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) <u>DELLA</u>			<b>4. DATE OF DEATH</b> <u>RENGEL</u>			<b>5. SEX</b> <u>FEMALE</u>			<b>6. COLOR OR RACE</b> <u>WHITE</u>											
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>12/30/1899</u>			<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																		
Months	Days	Hours	Min.																	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>												
<b>13. FATHER'S NAME</b> <u>Harry Easley</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Bennett</u>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <u>213-01-4513</u>		<b>17. INFORMANT</b> <u>Mrs Otilla Buchwald 2913 Onyx Road #34</u>														
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Carcinoma Right Breast - metastasis</u> <b>170A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>&gt; 1 year</u>										
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____												
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-21</u> , 19 <u>67</u> , <b>to</b> <u>4-10</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>4-9</u> , 19 <u>67</u> , <b>and that death occurred at</b> <u>7:45 PM</u> , <b>from the causes and on the date stated above.</b>																				
<b>22a. SIGNATURE</b> <u>David I. Miller</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>										<b>22b. DATE SIGNED</b>										
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>David I. Miller</u>						<b>22d. ADDRESS</b> <u>Linson Rd. Owings Mills, Md.</u>														
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>4-13-1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>			<b>23d. LOCATION (City, town or county)</b> <u>Baltimore</u> <b>(State)</b> <u>Md.</u>												
<b>24. FUNERAL DIRECTOR</b> <u>Lusabina Turner</u> <b>ADDRESS</b> <u>2401 Belair Road</u>						<b>25a. REC'D BY REGISTRAR</b> <u>APR 14 1967</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>											





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1

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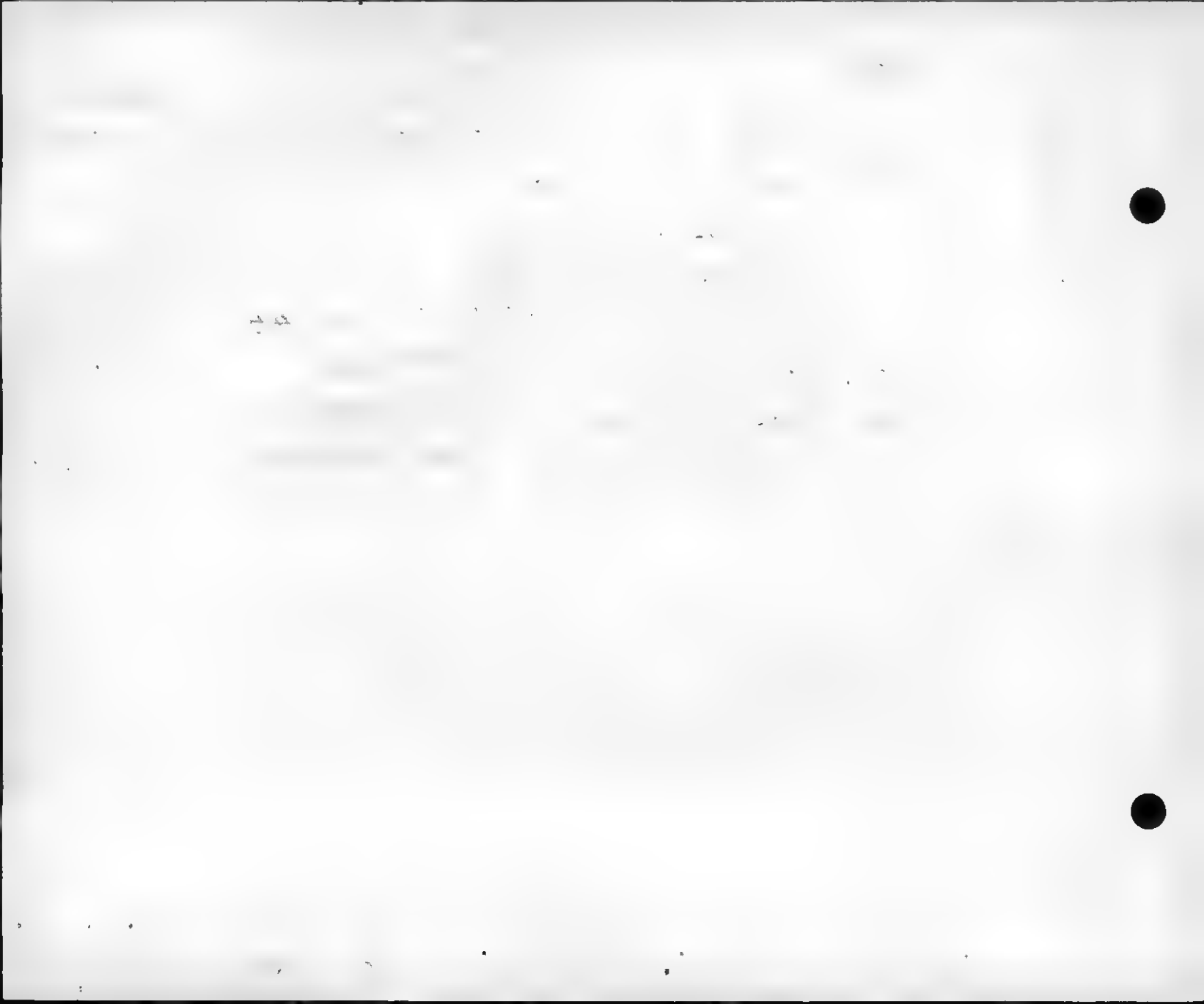
04872

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04872

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <u>BALTIMORE</u>		c. LENGTH OF STAY IN IT <u>10 Days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4709 Roland Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO. MED CENTER</u>		d. STREET ADDRESS <u>Baltimore</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>SHIRLEY ANN RICH</u>		4 DATE OF DEATH Month Day Year <u>APRIL 5 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>1-7-1922</u>
9 AGE (In years last birthday) <u>45</u>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>BALTO. md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Richard Howard Bond</u>		14 MOTHER'S MAIDEN NAME <u>MARGARET FURLONG</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOC. A. SECURITY NO. <u>217-18-3095</u>	
17 INFORMANT <u>MRS CLYDE A. WILSON-</u> (Pt's HISTORY) <u>4709 ROLAND AVE</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Ca. Ovary</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>/</u> DUE TO (c) <u>/</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-27-</u> , 1967, to <u>4/5/</u> , 1967 that (I) (we) last saw the deceased alive on <u>4/5/</u> 1967, and that death occurred at <u>11 55PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Ram K. Chhillar</u>		22b. DATE SIGNED <u>4/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHHILLAR</u>		22d. ADDRESS <u>GTR BALTO MED. CENTER</u> <u>BALTIMORE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> <u>Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04873

## CERTIFICATE OF DEATH

04873

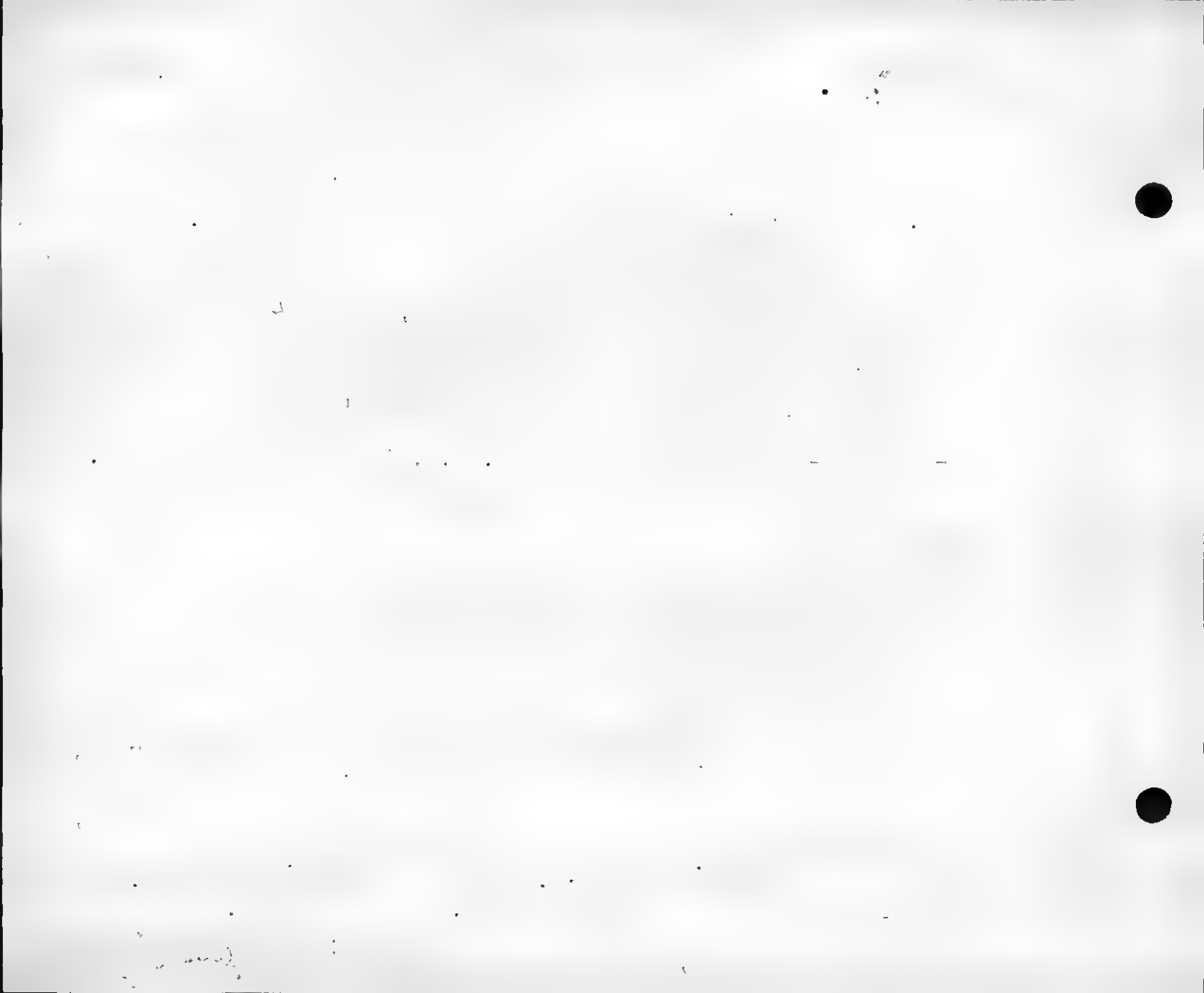
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1317 Register Avenue</b>		d. STREET ADDRESS <b>1317 Register Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Carleton</b> Middle <b>E.</b> Last <b>Robinson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1893.</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maine</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert F. Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Carrie E. Stevens</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>018-01-2440</b>	
17. INFORMANT <b>Mrs. Jennie M. Robinson</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>10 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>0</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>September 19 66</b> to <b>20 April 19 67</b> , that (I) (we) last saw the deceased alive on <b>20 April 19 67</b> , and that death occurred at <b>3 P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Abraham Genevin</b>		22b. DATE SIGNED <b>20 April 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ABRAHAM GENEVIN M.D.</b>		22d. ADDRESS <b>611 PARK AVE BALTIMORE MD 21201</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>4/21/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>APR 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
04874		04874	
1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY <b>Baltimore</b> MARYLAND		a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>4638 Marble Hall Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <b>ISABELLE I. RODDY</b>		Month Day Year <b>April 7, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1882</b>
		9. AGE (In years last birthday) yrs <b>84</b>	IF UNDER 1 YEAR Months Days Hours Mins. <b>1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>(?) Fulton</b>		14. MOTHER'S MAIDEN NAME <b>Frances O'Brien</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. A.F.O'Brien-706 Dunkirk Rd. 12</b>		Address	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Terminal pneumonia</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <b>March 31, 1967</b> to <b>April 7, 1967</b> , that (he) last saw the deceased alive on <b>April 7, 1967</b> , and that death occurred at <b>2:36 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Regalado T. Dizon</b> M.D.		22b. DATE SIGNED <b>April 7, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Regalado T. Dizon M.D.</b>		22d. ADDRESS <b>7620 York Rd. Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>4/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO.</b>
24. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME INC.</b> <b>6500 YORK ROAD, 21212</b>		25a. RECEIVED BY REGISTRAR <b>APR 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

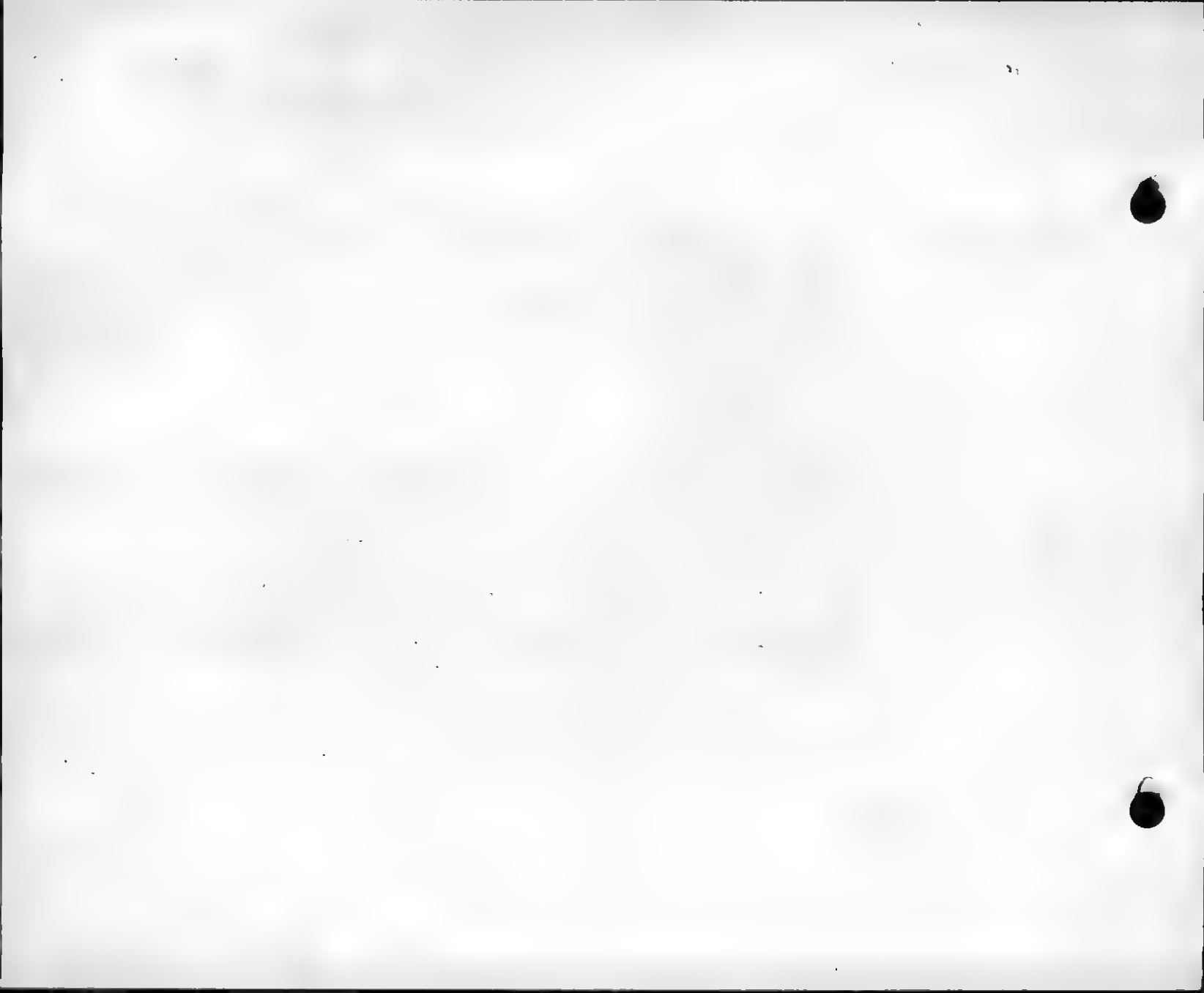
04875

CERTIFICATE OF DEATH

04875

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1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2920 NISS AVE</u>		d. STREET ADDRESS <u>2920 NISS AVE</u>	
3 NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>M</u> Last <u>ROHNER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 20 1902</u>
9 AGE (In years lost birthday) <u>64</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>MINN</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DOMINIC WATERIN</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA THOMAS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17 INFORMANT <u>FAMILY RECORDS</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema Congest Heart Failure</u> DUE TO (b) <u>Intermittent Cardio-Vascular disease</u> DUE TO (c) <u>Generalized lymphomatosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized debilitation precipitating #1 above</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Apr</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/31/67</u> , and that death occurred at <u>10:45 PM</u> , from causes on and the date stated above.			
22a SIGNATURE <u>Frank T. Kasik Jr.</u>		22b DATE SIGNED <u>4/3/67</u>	
22c PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR.</u>		22d ADDRESS <u>9005 HARTFORD RD. BALTO MD.</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>4-5-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>	23d LOCATION (City or town) (County) (State) <u>BALTO CO. MD</u>
24 FUNERAL DIRECTOR <u>C. F. EVANS &amp; SON</u>		25a REC'D BY REGISTRAR <u>APR 5 1967</u>	
25b REC'D BY SIGNATURE <u>[Signature]</u>			





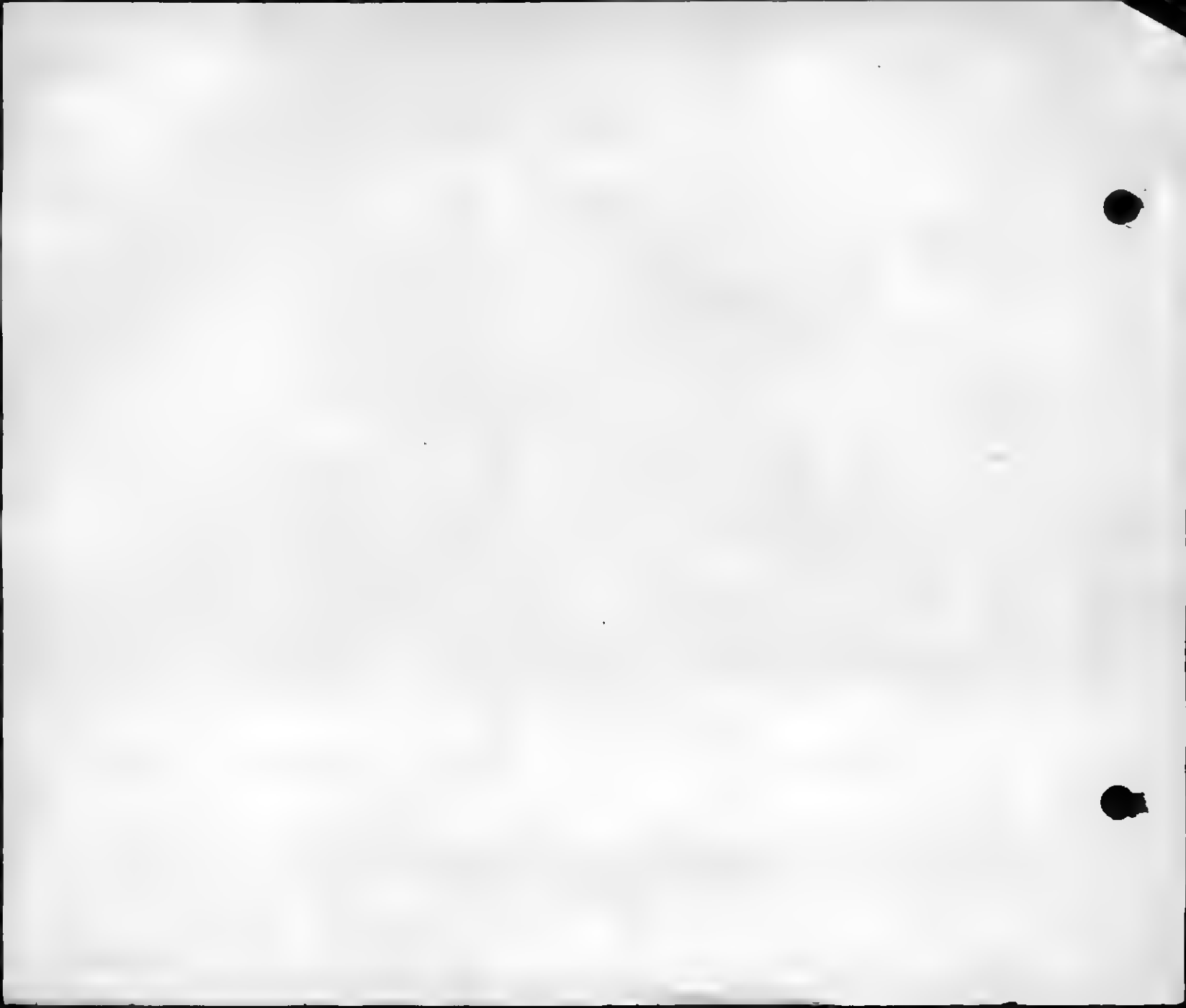
FOR-STATE  
HEALTH-DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04876

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rosedale.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rosedale.</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>7934 Berk Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7934 Berk Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude C. Rosenthal</u>		4. DATE OF DEATH <u>April 22 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-03</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		FUNDING YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri, USA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Freida Storm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Raymond E. Rosenthal</u>		Address <u>7934 Berk Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/22/67</u> <u>Dr. Davis</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/25/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathawn Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Lewis</u>		24a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
ADDRESS <u>1211 Chesebrough Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. File its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04877

04877

1. PLACE OF DEATH a. COUNTY <u>LOWSON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4213 SPRINGDALE AVE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DULANEY-TOWSON NURSING HOME</u>							
3. NAME OF DECEASED (Type or print) <u>ELFRIEDE</u>				4. DATE OF DEATH <u>ROSS</u> <u>APRIL 18</u> <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 27, 1903</u>	
9. AGE (in years last birthday) <u>63</u> yrs				10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>HERBERT ROSS</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Metastasis</u> DUE TO (b) <u>Carcinoma of the colon (hepatic flexure)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Ant. Sch. Heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1941</u> to <u>April 18, 1967</u> that (I) (we) last saw the deceased alive on <u>April 18, 1967</u> and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis V. Blum, M.D.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>LOUIS V. BLUM, M.D.</u>				22d. ADDRESS <u>3502 W. Rogers Ave Balto Md 21215</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>4/20/67</u>		<u>Har Sinai</u>		<u>Balto, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis &amp; Son, Inc</u>				25a. REC'D BY REGISTRAR <u>Garrison, Md</u>			
25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>				DATE <u>APR 21 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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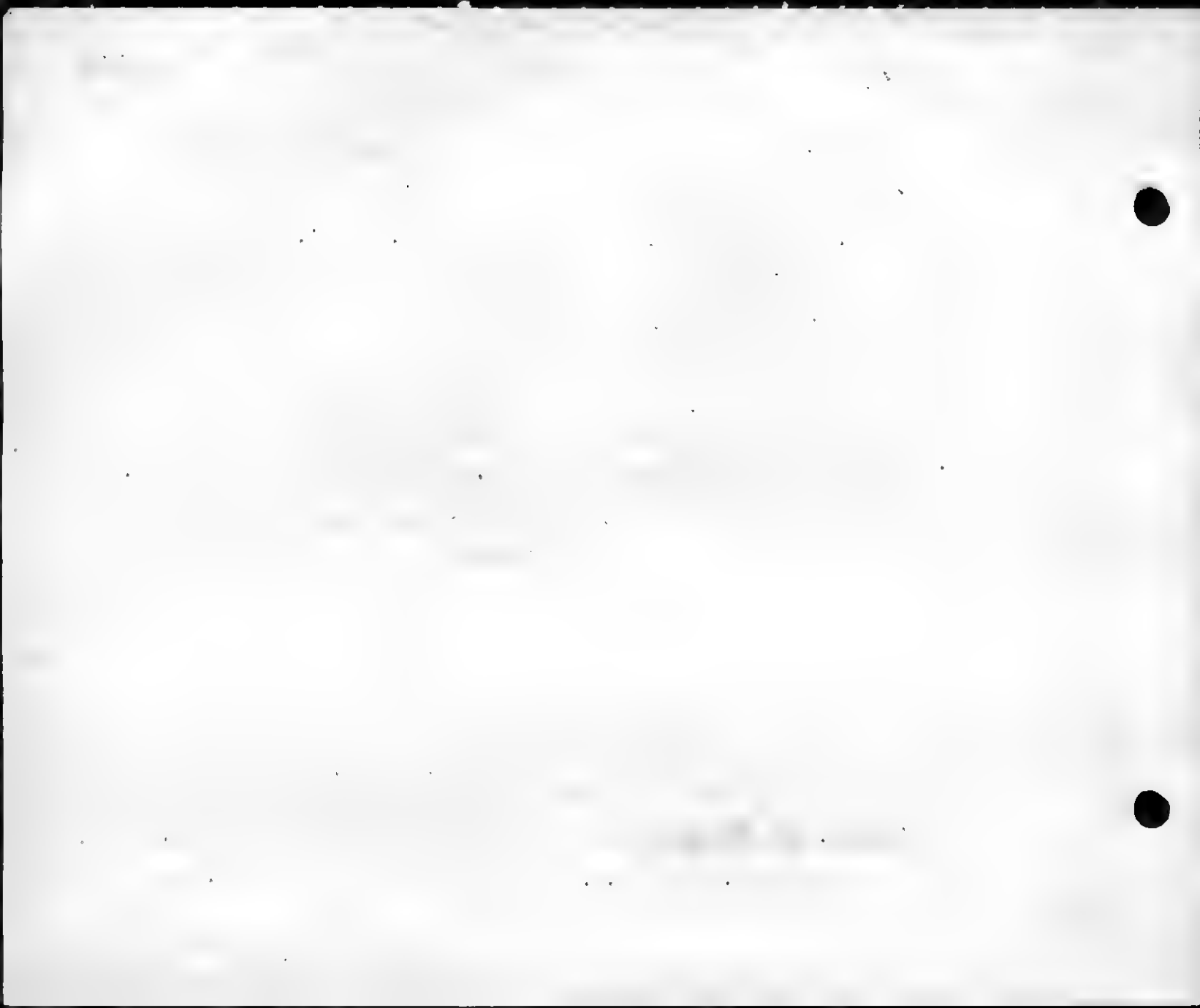
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04878

CERTIFICATE OF DEATH

04878

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c LENGTH OF STAY IN 1b <b>Baltimore 21231</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>230 S. Ann St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank RUMINSKI</b>		4 DATE OF DEATH Month Day Year <b>April 13 19 67</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/31/1888</b>
9. AGE (in years last birthday) <b>79 yrs</b>		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Tailor</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Clothing Tailoring</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Poland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ruminski</b>		14. MOTHER'S MAIDEN NAME <b>Maryanna Kaczan</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>217-07-0963 A</b>	
17 INFORMANT <b>Mrs. Bertha Zarachowicz</b>		Address <b>321 S. Newkirk St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Osteo arthritis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 6, 19 67</b> , to <b>April 13, 19 67</b> , that (I) (we) last saw the deceased alive on <b>April 13 1967</b> , and that death occurred at <b>2a M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>April 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez M.D.</b>		22d ADDRESS <b>7620 York Rd. Towson 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>M.F. BADOWSKI &amp; SONS, 1808 EASTERN AVE.</b>		25a REC'D BY REGISTRAR <b>APR 17 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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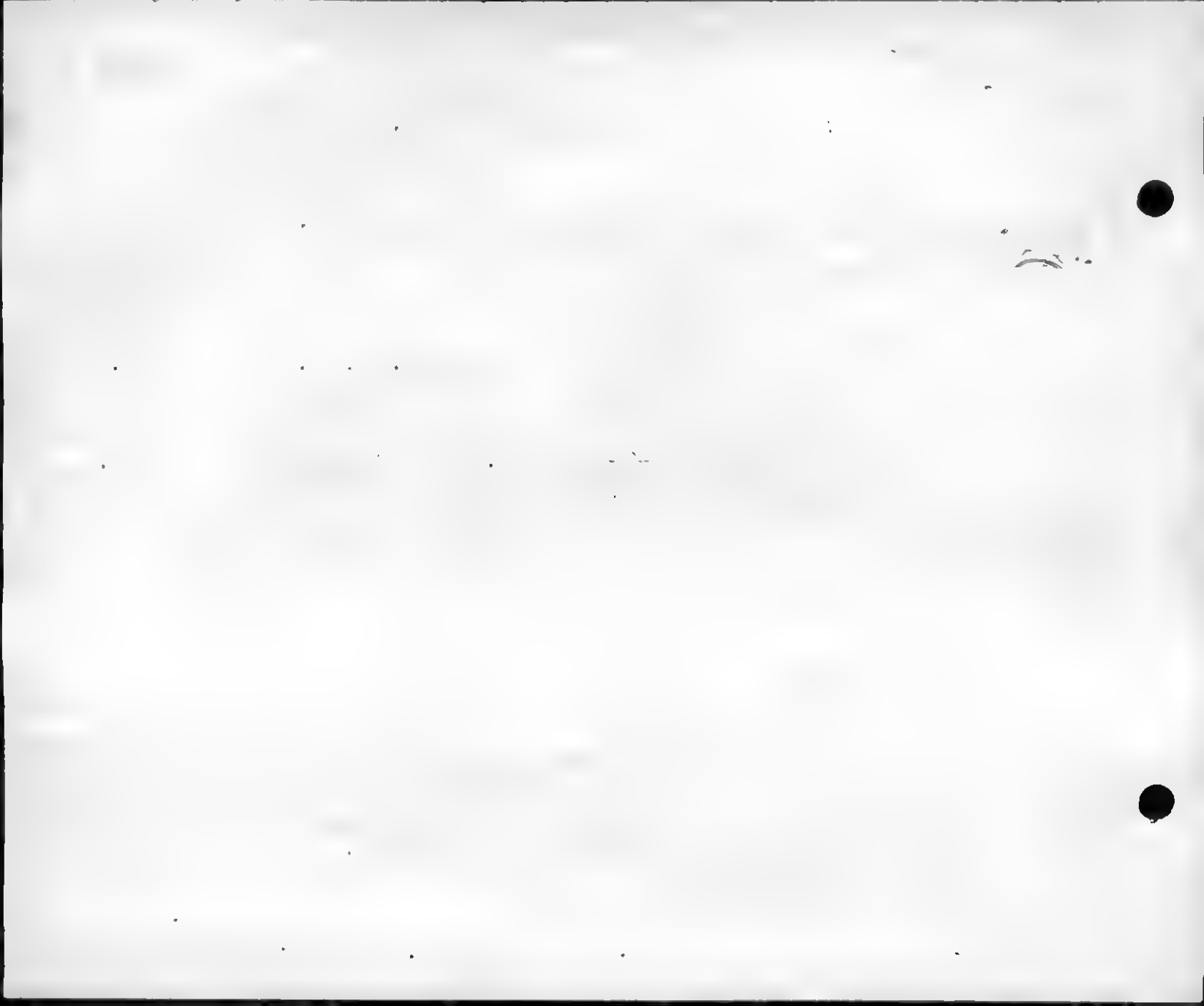
BP

04873

CERTIFICATE OF DEATH

04879

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown 21133</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>				d. STREET ADDRESS <u>8536 Liberty Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Edwin H. Russell</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>8</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-28-05</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>12</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balt. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edie Lynd Russell</u>				14. MOTHER'S MAIDEN NAME <u>Alice Arndt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-38-8285</u>		17. INFORMANT <u>Mrs. Russell Sprague-8739 Liberty Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension and Respiratory Depression</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial Infarction</u> DUE TO <u>BCVD</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>12 hrs</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute leukemia &amp; severe anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>67</u> , to <u>4-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-8</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Angelita T. Paul</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANGELITA T. PAUL</u>				22d. ADDRESS <u>BC 211</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md. 21208</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-5728 Liberty Rd.</u>				ADDRESS <u>Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	



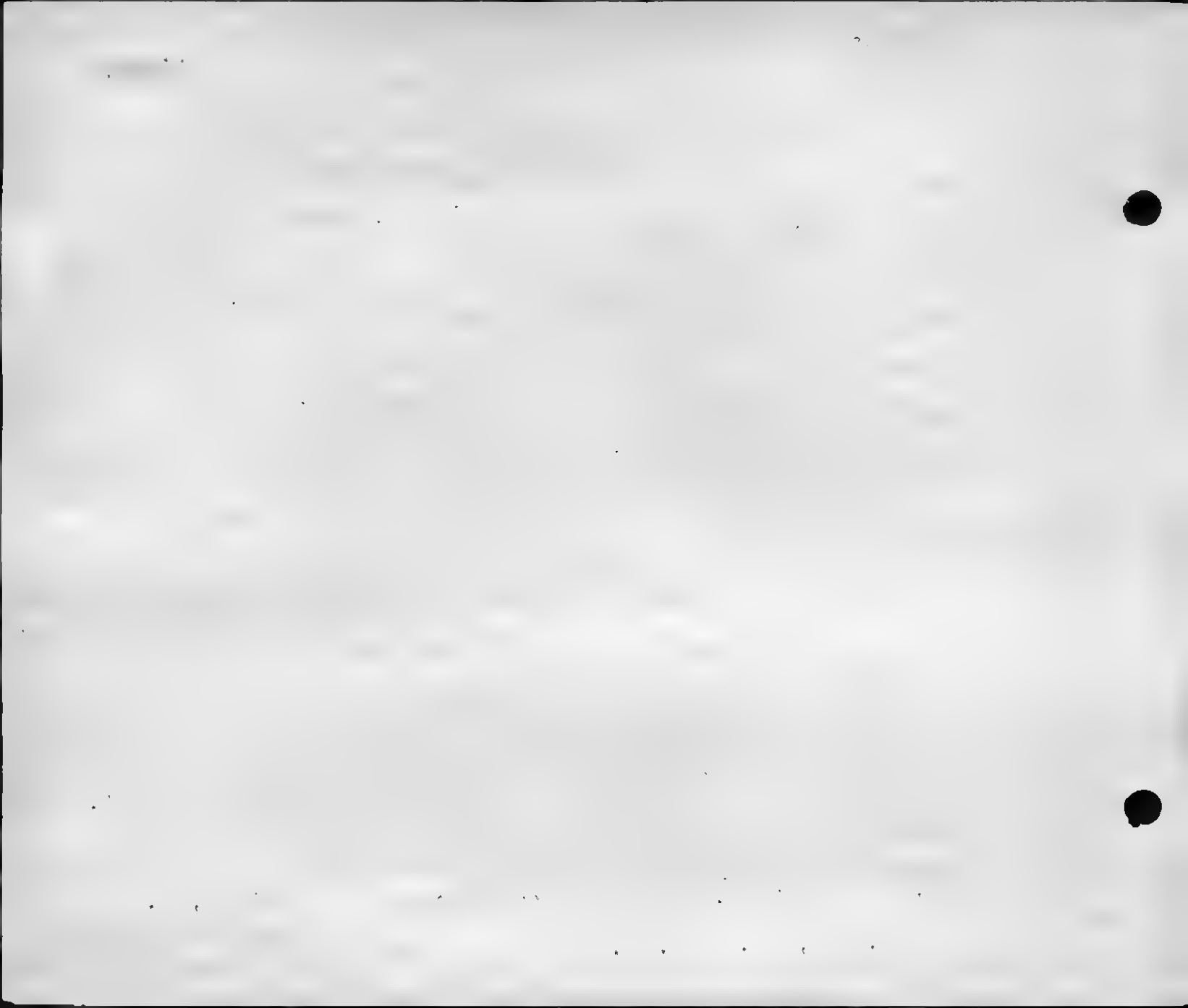


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VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH e. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE		b. COUNTY	
Daltimore		Daltimore		4 yrs		Md.		Daltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		f. NAME OF DECEASED (Last, first, middle)		g. DATE OF DEATH		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Stella Maria Hospice		Rosa P. Russo		4/10/67					
3. NAME OF DECEASED (Type or print)		7. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
Rosa P. Russo				1/1/1878		47 yrs		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None				Sicily, Italy		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Ignatius Papale		Emma (family name unknown- 1663)		None		Hospice Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		DUE TO					
Acute Myocardial Infarction		ASCVD		Dietary intake					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
19									
21. I certify that (I) (this hospital) attended the deceased from March 12, 1967, to Apr. 10, 1967, that (I) (we) last saw the deceased alive on Apr. 10, 1967, and that death occurred at 9:15 AM on the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED					
Robert A. Mahon		4/10/67							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Robert T. Mahon MD		204 E. Jones St.		Burial		4/12/67		Holy Redeemer Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc. Balto. Md. 21214		APR 11 1967		Charles J. J.					



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

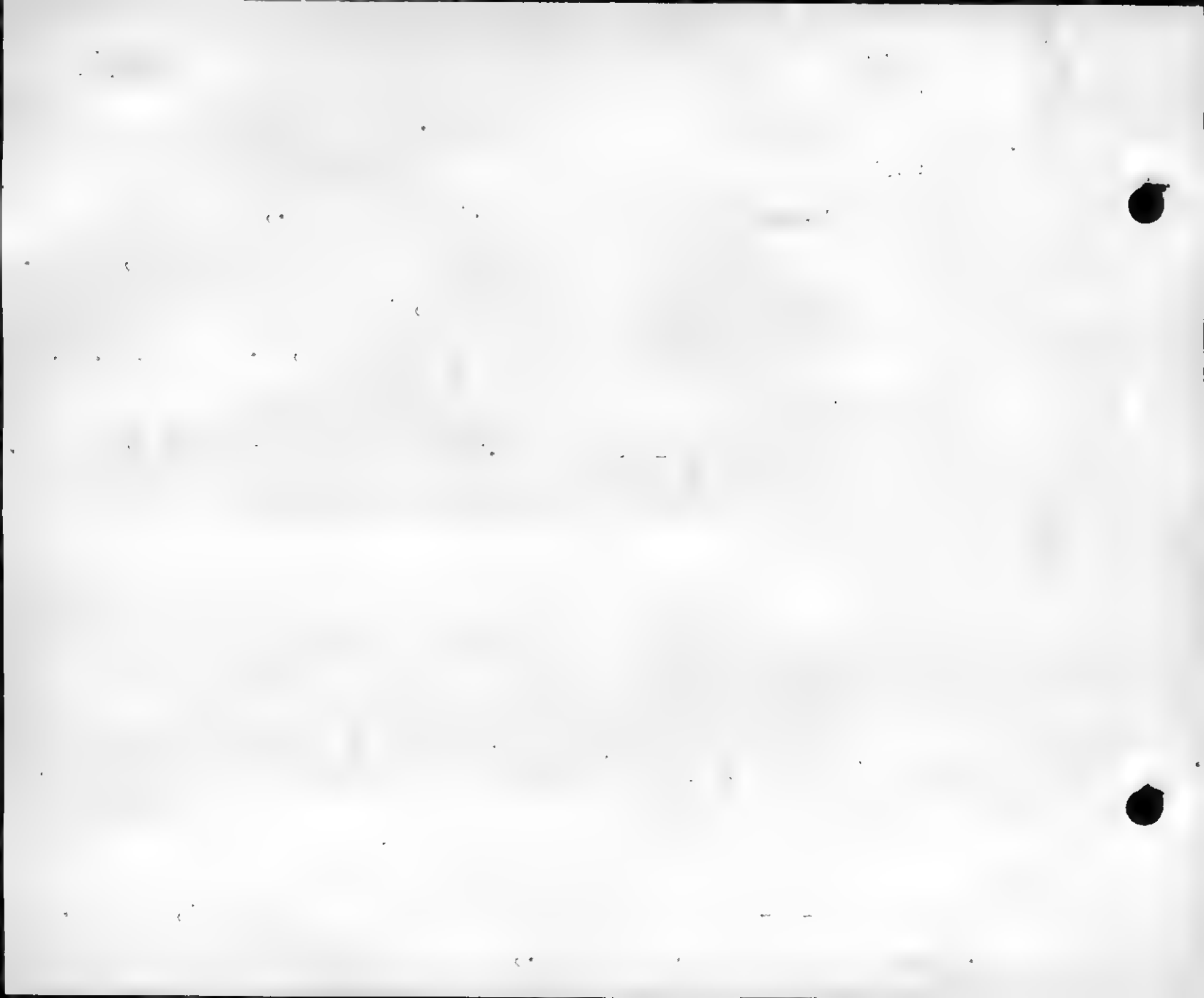
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04881

## CERTIFICATE OF DEATH

04881

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>28 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3309 Elgin Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Sauer</b> Last <b>Sauer</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1880</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>14</b> Hours <b>14</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Corp.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Justus Sauer</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Menkel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-20-9333</b>		17. INFORMANT Address <b>Mrs. Edna M. Steedman 552 Alleghany Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/30</b> , 19 <b>67</b> , to <b>4/25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/24</b> , 19 <b>67</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert A. Retter</b>						22b. DATE SIGNED <b>4/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Retter, M.D.</b>						22d. ADDRESS <b>606 Edmonson Ave. 21238</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-27-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>G. Howard Strong 3207 W. North Ave.,</b>				25a. REC'D BY REGISTRAR <b>APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>William J. ...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

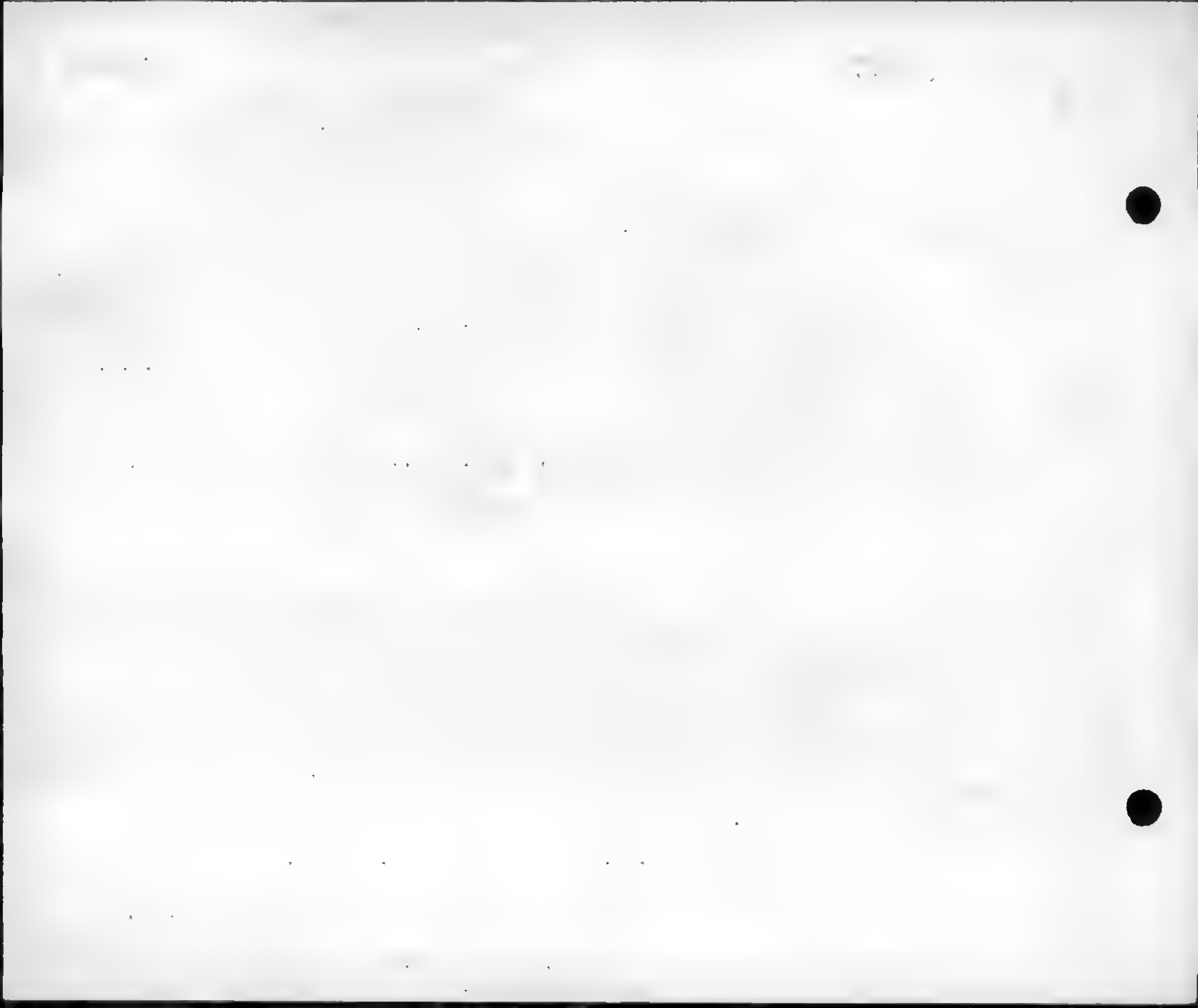
04882

CERTIFICATE OF DEATH

04882

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>46 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1332 MYRTLE AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>IRA</b> Middle <b>LEE</b> Last <b>SAVAGE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APRIL 27, 1932</b>
9 AGE (In years last birthday) <b>35</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EQUIPMENT OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>SEWELL SAVAGE</b>		14 MOTHER'S MAIDEN NAME <b>LULA DOWNING</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES PL-28</b>		16. SOCIAL SECURITY NO. <b>229 39 47 03</b>	
17. INFORMANT <b>CLIN. REC., VAH, FORT HOWARD, MARYLAND</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RETICULUM CELL SARCOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 14, 1967</b> to <b>April 29, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 29, 1967</b> , and that death occurred at <b>10:00 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>George Dudas</i>		22b. DATE SIGNED <b>4 29 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>		22d. ADDRESS <b>VAH, Ft. Howard, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>5/5/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Church Cem</b>	23d LOCATION (City or Town) (County) (State) <b>Accomac Co. Va.</b>
24 FUNERAL DIRECTOR <i>George G. Kelson</i>		25a REGD. BY REGISTRAR <b>MAY 1 1967</b>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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VR A15 (4)  
25M 1/67

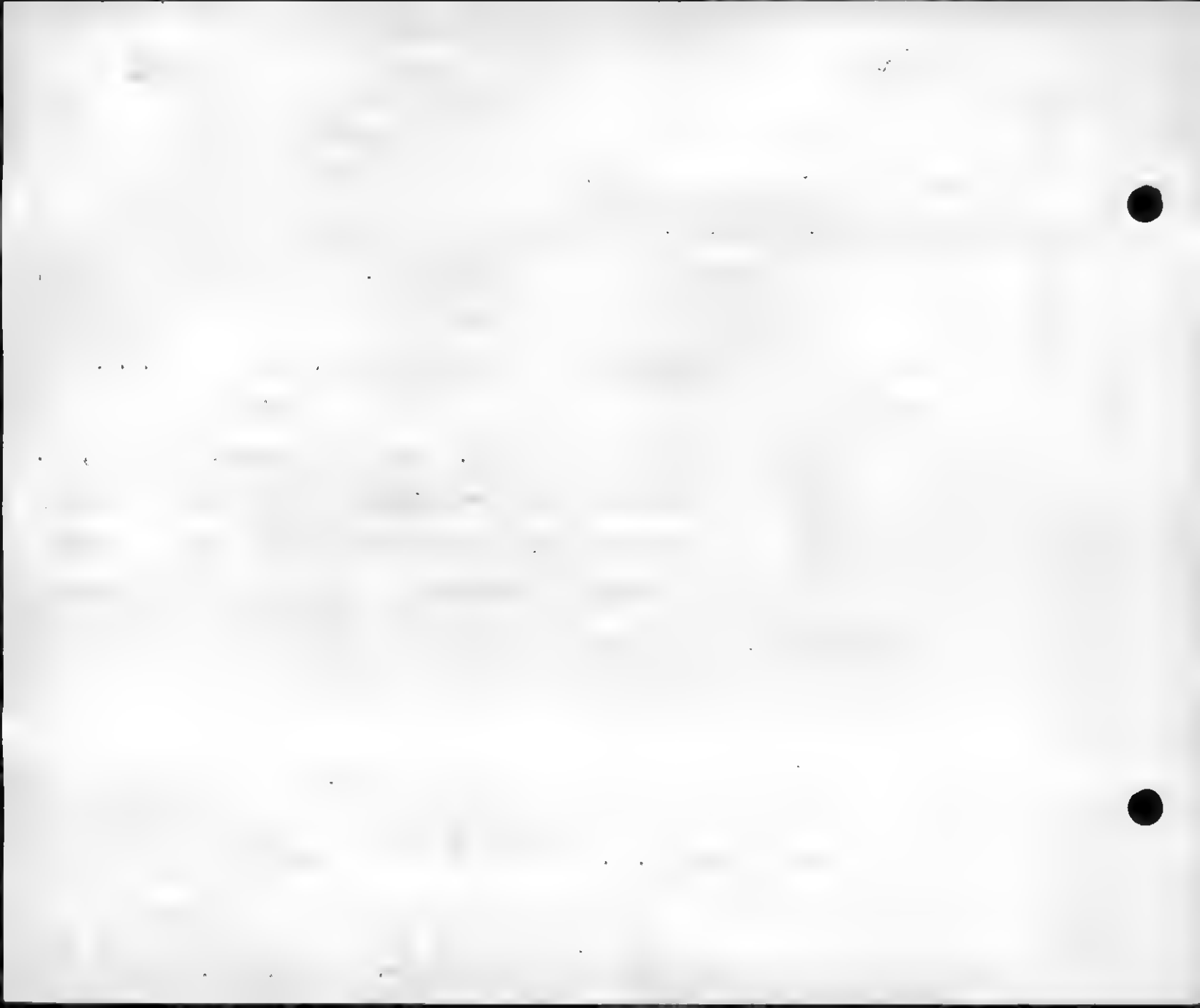
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04883

CERTIFICATE OF DEATH

04883

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY N 1b <b>19 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>315 INGLESIDE AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>ANTHONY</b> Last <b>SCHAKUS, JR.</b>		4 DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MARCH 24, 1892</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TAILOR SHOP</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANTHONY SCHAKUS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA MN: UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>216 01 63 21</b>	
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>THROMBOSIS RIGHT MIDDLE CEREBRAL ARTERY, ACUTE</b> DUE TO (b) <b>THROMBOSIS LEFT MIDDLE CEREBRAL ARTERY, REMOTE</b> DUE TO (c) <b>CEREBRAL ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/17/67</b> , 19 <b>67</b> , to <b>4/5/67</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/5/67</b> , 19 <b>67</b> , and that death occurred at <b>11:30 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Nielson Neilson</i>		22b. DATE SIGNED <b>4/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NIELSON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR <i>John J. Cowan &amp; Son</i>		25a. REC'D BY REGISTRAR <b>1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>HOLLINS &amp; POPPLETON STS. BALTIMORE, MD.</b>	





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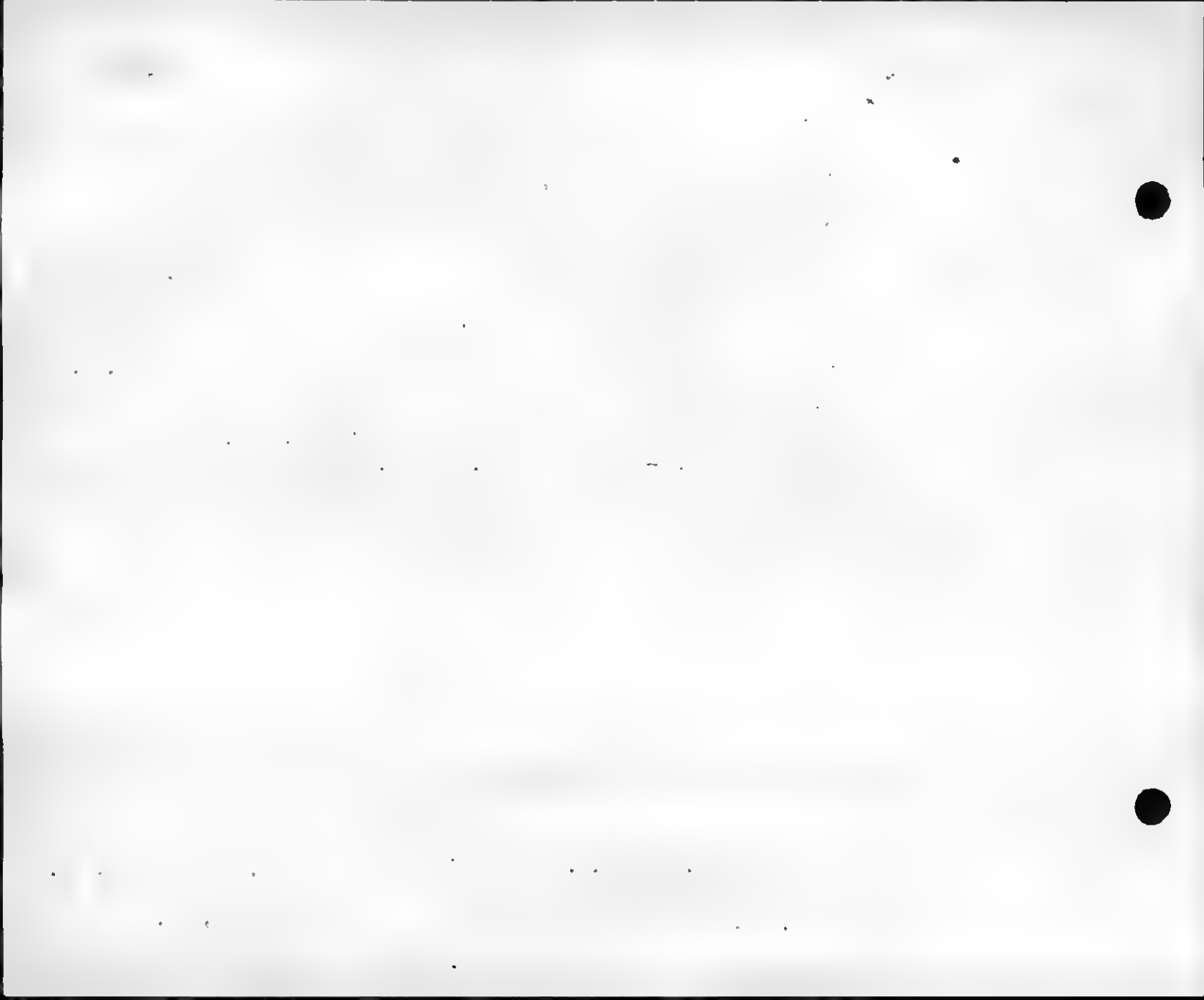
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04884

CERTIFICATE OF DEATH

04884

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>65 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>700 Academy Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katherine Veronica Schaub</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 2, 1879</b>
9. AGE (In years last birthday) <b>88 yrs</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Nicholas Stumpf</b>		14. MOTHER'S MAIDEN NAME <b>Christina Rossman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-50-9184 T</b>	
17. INFORMANT <b>Mrs. Mary C. Schaub</b>		Address <b>700 Academy Road Catonsville, Md. 21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO <b>HEART</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CHRONIC CORONARY DISEASE - CATHETER</b> DUE TO <b>DISEASE</b> (c) <b>DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>66</b> , to <b>4/14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/14</b> , 19 <b>67</b> , and that death occurred at <b>5:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>John H. Shaw</i>		22b. DATE SIGNED <b>4/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D.</b>		22d. ADDRESS <b>5800 Edmondson Ave. Catonsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Catonsville Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 1967</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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VR A15 (4)  
20 M 1/66

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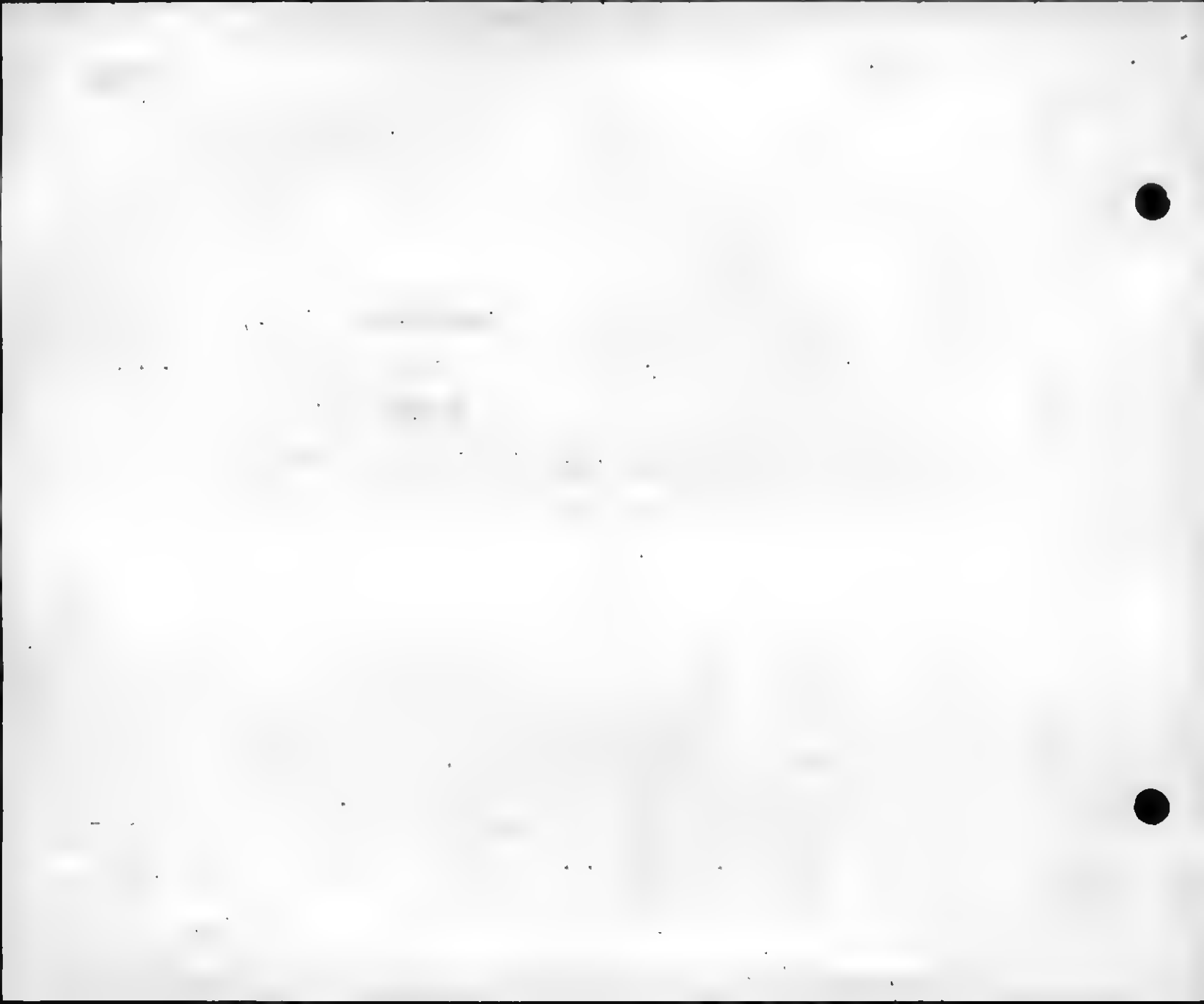
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04885

CERTIFICATE OF DEATH

04885

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN "b" <b>20yr3mth24dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>3606 Lucille Avenue #15</b>			
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Schilansky</b> Last <b>Schilansky</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>XXXXXXXXXXXX</b>	9. AGE (In years last birthday) <b>NEAR 77</b>	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>		IF UNDER 24 HRS Hours <b>—</b> Min <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jake Cohen</b>				14. MOTHER'S MAIDEN NAME <b>ANNA ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>218-22-1035A</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonia</b> DUE TO (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> o.m. <b>—</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Dec. 23, 19 46</b> to <b>April 17, 19 67</b> that (1) (we) last saw the deceased alive on <b>April 17, 19 67</b> , and that death occurred at <b>4:05</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Evelio A. Felipe, M.D.</b>				22b. DATE SIGNED <b>4-17-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Evelio A. Felipe, M.D.</b>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <b>B</b>				23b. DATE THEREOF <b>4/19/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bir Chayim</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson</b>				25a. ADDRESS <b>8 Bros. In c., 6010 Reisterstown</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25a. REC'D. BY REGISTRAR <b>APR 21 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

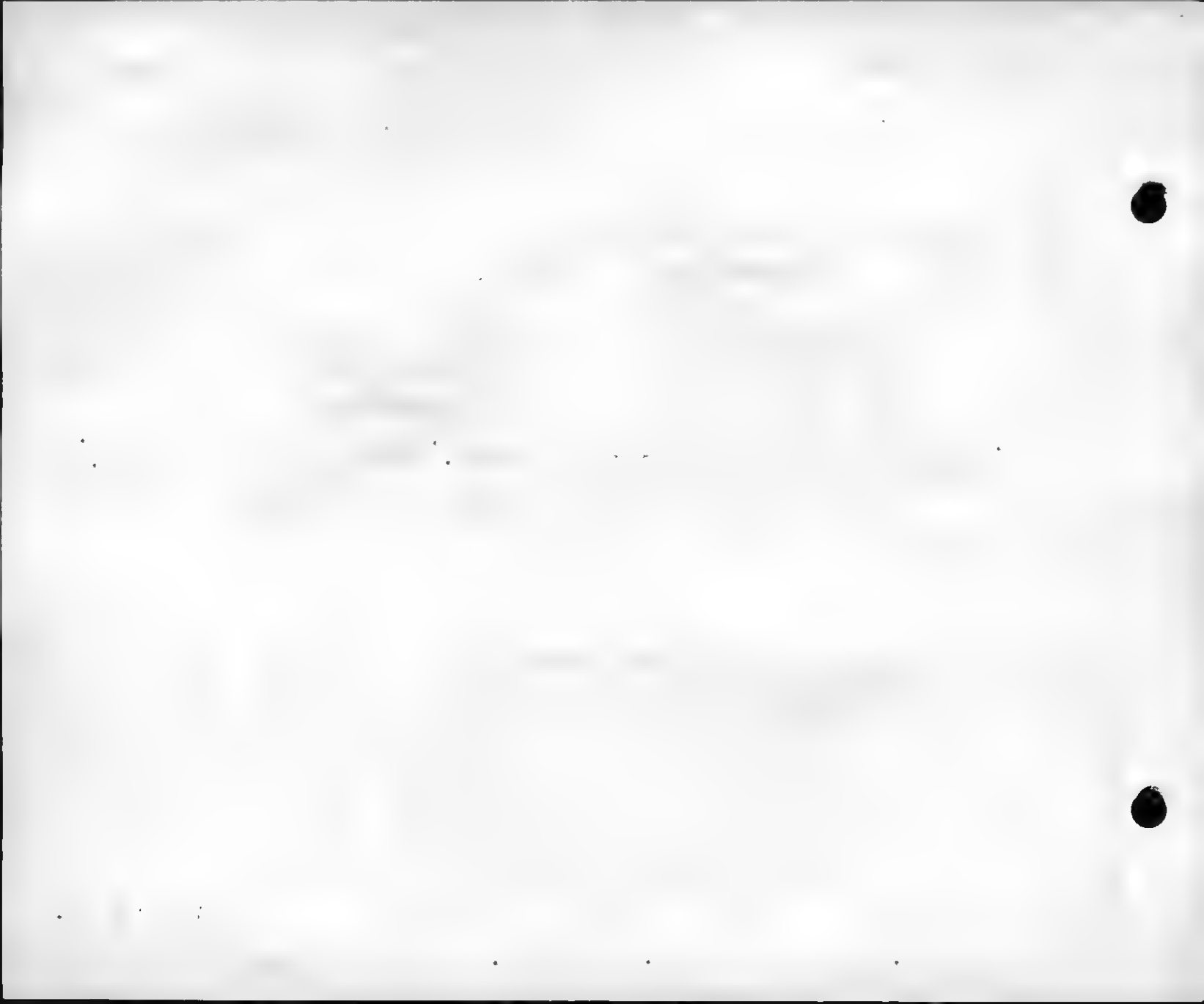
04886

CERTIFICATE OF DEATH

04886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
c. LENGTH OF STAY IN TB <u>1 day</u>		d. STREET ADDRESS <u>10110 Fontaine Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Schriefer</u> Last <u>Schriefer</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u> RACE <u>White</u>		6. DATE OF BIRTH <u>9-9-28</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>38</u> yrs	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kotch</u>		14. MOTHER'S MAIDEN NAME <u>Florence Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-22-4409</u>	
17. INFORMANT (Husband) <u>John A. Schriefer, 10110 Fontaine Dr.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio - Resp. Failure</u> <u>170X</u> DUE TO (b) <u>Carcinoma of Breast,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Pulmonary metastases</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/4/1967</u> to <u>4/5/1967</u> that (I) (we) last saw the deceased alive on <u>4/5/1967</u> , and that death occurred at <u>5:45</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>Dennis Chan</u>		22b. DATE SIGNED <u>4/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN M.D.</u>		22d. ADDRESS <u>67B MC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Duda</u>		25a. REC'D BY REGISTRAR <u>APR 10 1967</u>	
ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



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1

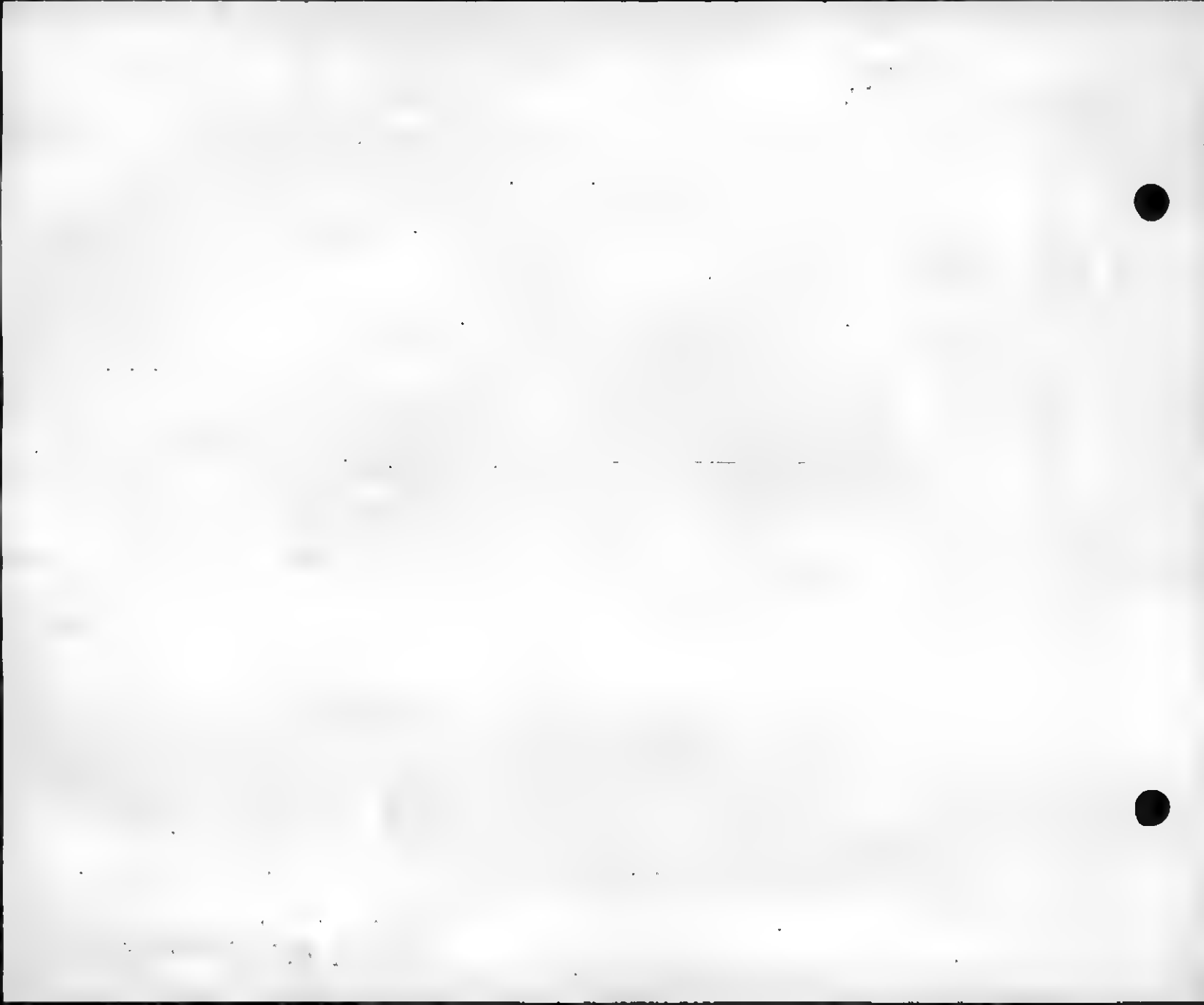
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04887

CERTIFICATE OF DEATH

04887

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 3 mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home &lt;</b>		d. STREET ADDRESS <b>508 E. Toppa Road 693 Gladstone</b>	
3 NAME OF DECEASED (Type or print) <b>EMMA T. SCHULTZE</b>		4. DATE OF DEATH <b>April 8, 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Dec. 23, 1875</b>
9 AGE (In years last birthday) <b>91</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Otto Tuerke</b>		14 MOTHER'S MAIDEN NAME <b>Elizabeth Festman</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-01-2572</b>	
17. INFORMANT <b>Mr. Alvin E. Schultze, Flushing, New York</b>		Address <b>138-10 Franklin Ave.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.-V. Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b> <b>15 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>January 1950</b> to <b>April 8, 1967</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>April 8, 1967</b> , and that death occurred at <b>11:00 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A. Allan Spier</b>		22b. DATE SIGNED <b>4/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Allan Spier, M.D.</b>		22d ADDRESS <b>1501 Pentridge Rd., Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 11, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson,</b>		25a. REC'D BY REGISTRAR <b>APR 11 1967</b>	
ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





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VR A15 (4)  
20 M 1/66

MD  
1

04888

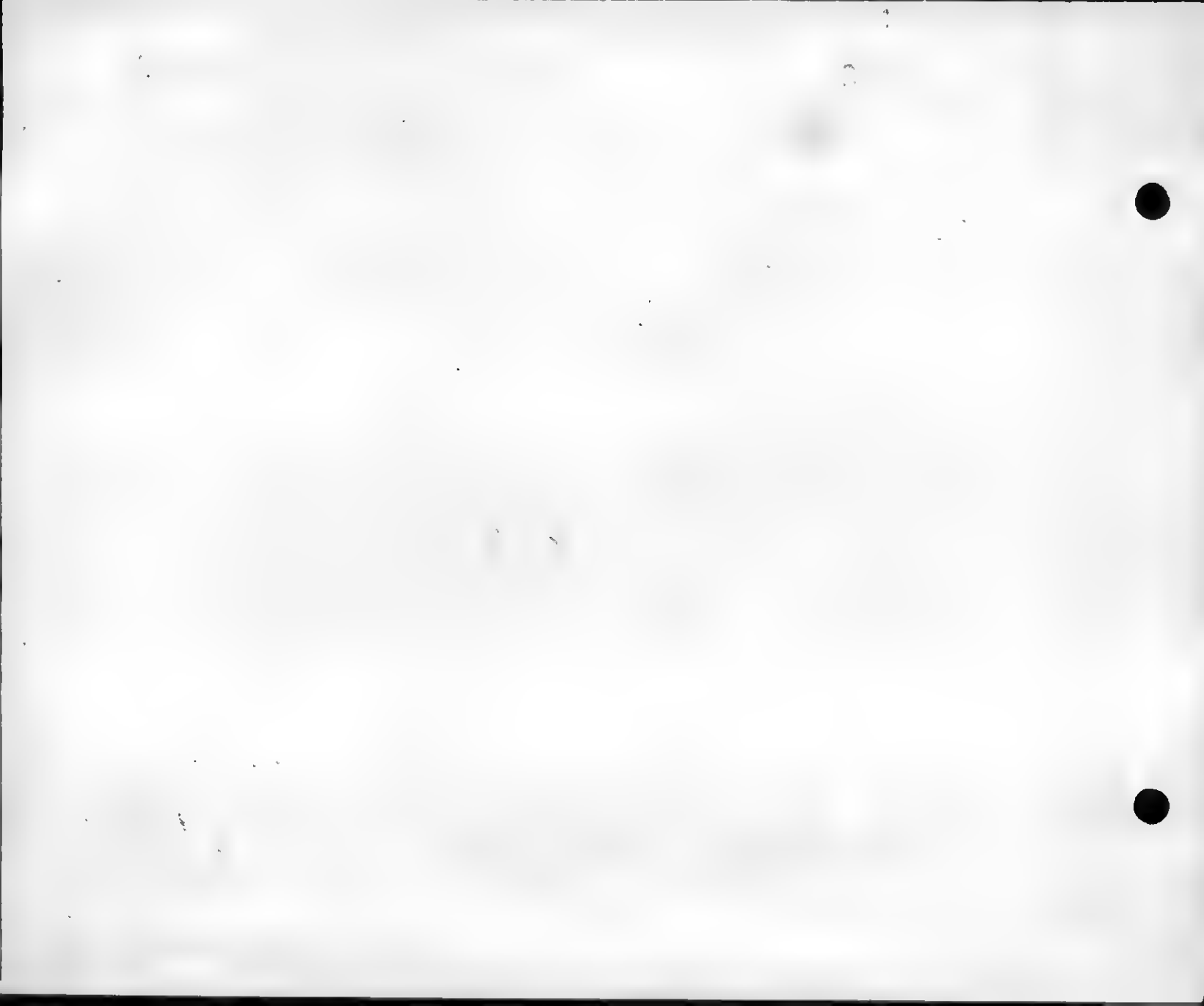
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2b,c & d Fill in by 4/12/67 pc

CERTIFICATE OF DEATH

04888

1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>13611001 Wic.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. LENGTH OF STAY IN 1b <u>since 1962.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville Salisbury</u>		d. STREET ADDRESS <u>127 Granby Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland Masonic Homes</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE L. SCHWARTZ</u>		4 DATE OF DEATH Month Day Year <u>4 13 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 29 1902.</u>
9. AGE (In years last birthday) <u>65 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) <u>house wife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Council Bluffs Iowa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John W Lowman.</u>		14. MOTHER'S MAIDEN NAME <u>Blaiche Robey.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO <u>213-16-7336</u>	
17. INFORMANT <u>Maryland Masonic Home Packer, son</u>		Address <u>md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Ventricular standstill</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 14 1965</u> , to <u>April 12 1967</u> , that (I) (we) last saw the deceased alive on <u>April 12 1967</u> , and that death occurred at <u>9:38 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Jamshid Hamed MD.</u>		22b. DATE SIGNED <u>4/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED MD.</u>		22d. ADDRESS <u>COCKEYSVILLE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>Apr 17 1967</u>	<u>St. Andrews</u>	<u>Princess Anne Md</u>
24. FUNERAL DIRECTOR <u>Wm Cork-Brooks Towson</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 1967</u>	
ADDRESS <u>1050 York Rd Towson, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

21204

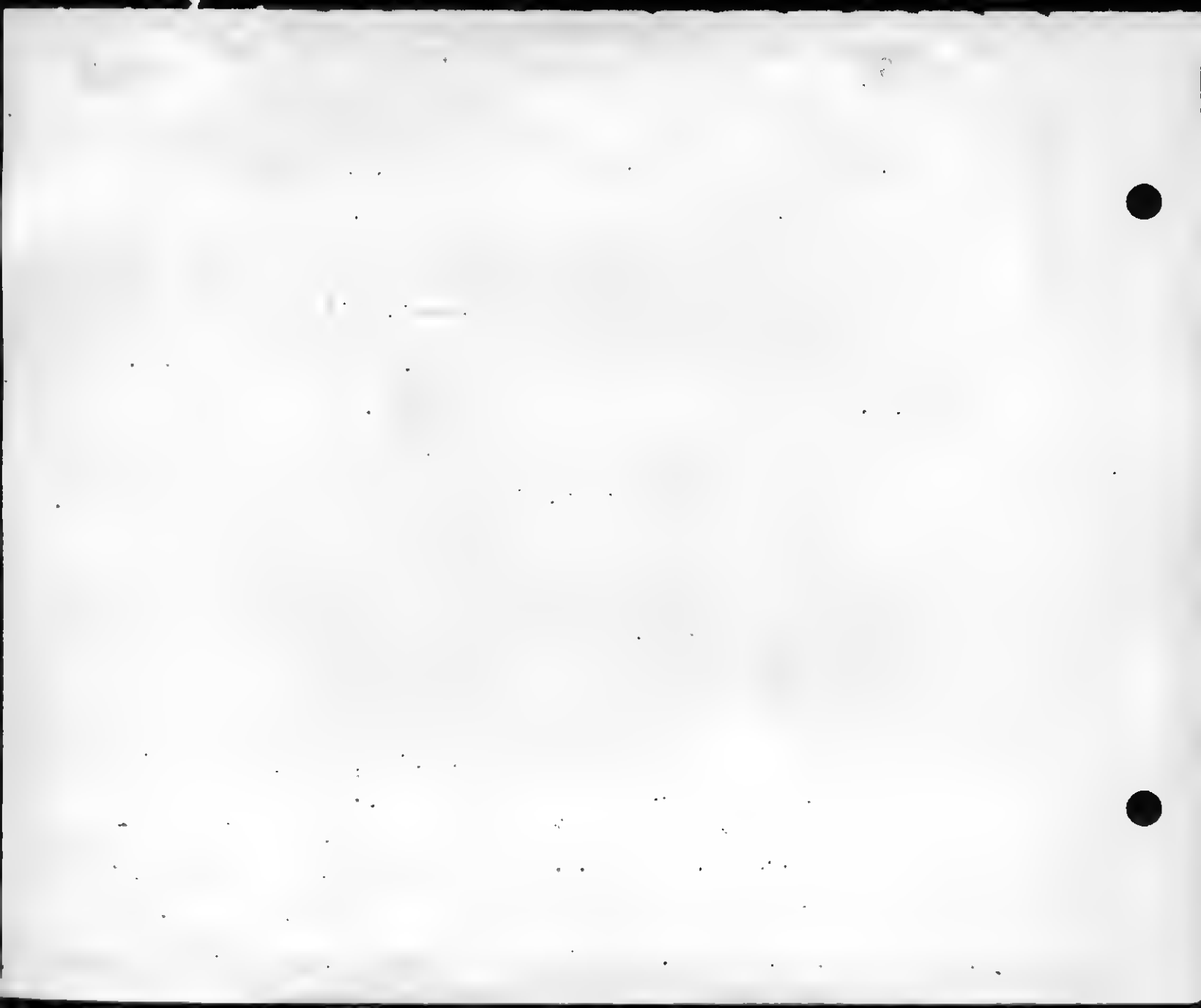


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04889 CERTIFICATE OF DEATH 04889

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN ID <b>1mth17dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>2812 Dunlaw Court</b>	
3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>Seward</b> Last <b>Seward</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James T. Lawrence</b>		14. MOTHER'S MAIDEN NAME <b>Amelia T.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>March 10, 1967</b> to <b>April 27, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>April 27, 1967</b> , and that death occurred at <b>1:10</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED <b>4-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/1/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>	23d. LOCATION (City, town or county) (State) <b>BALTO. CO. Md</b>
24. FUNERAL DIRECTOR <b>W. Burt Prochly, Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

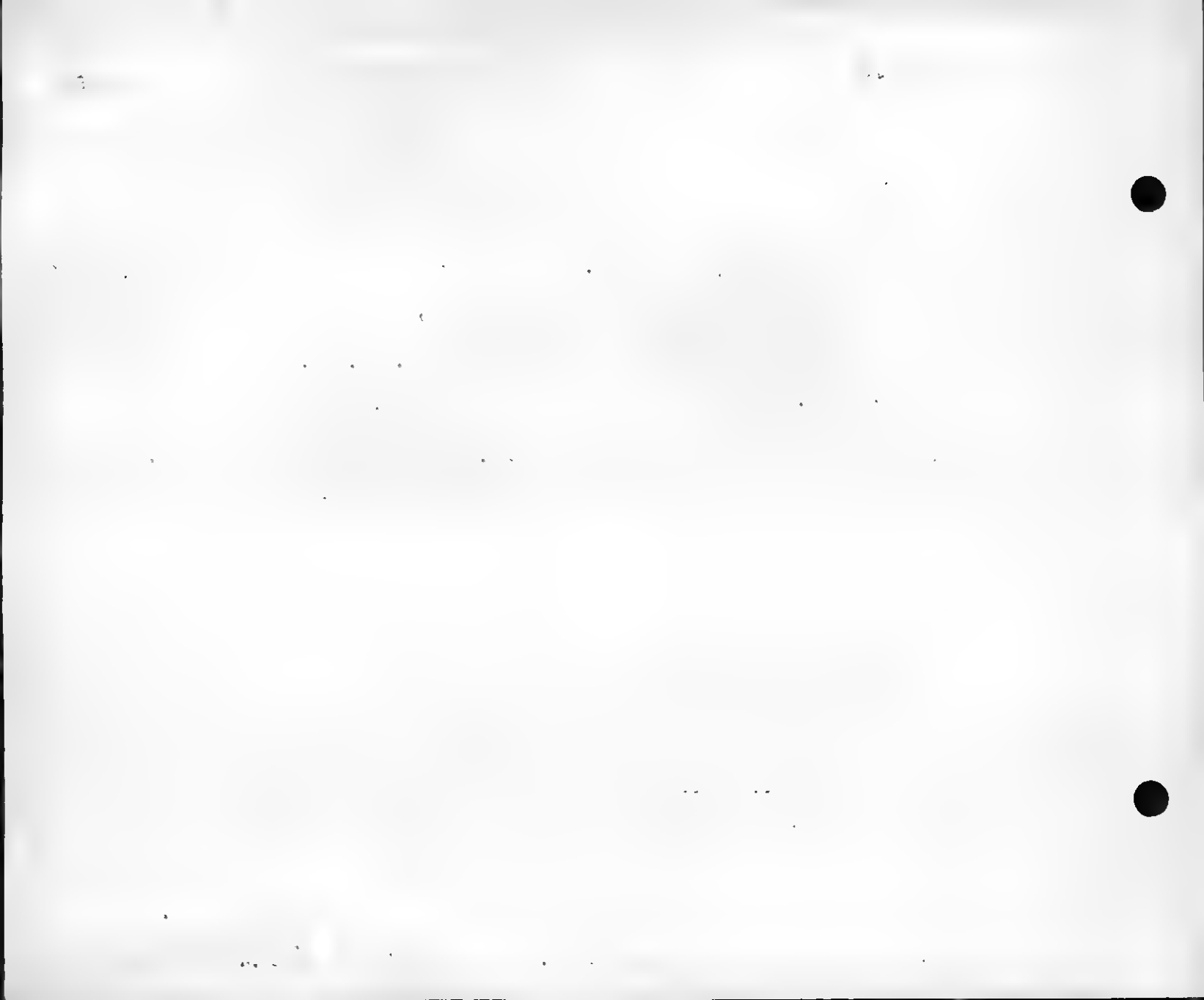
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04890

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04890

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN b. <b>6 1/2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>				d. STREET ADDRESS <b>Pennington Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>SEWARD</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 4, 1894</b>	9 AGE (In years last birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days hours Min		IF UNDER 24 HRS hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired From State Roads</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>Thomas W. Seward</b>				14. MOTHER'S MAIDEN NAME <b>Jane E. Baublitz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-2779</b>		17. INFORMANT <b>Mrs. Maxine Seward Glyndon, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> <b>1551</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>4/8/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 11, 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Butler Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Jones</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

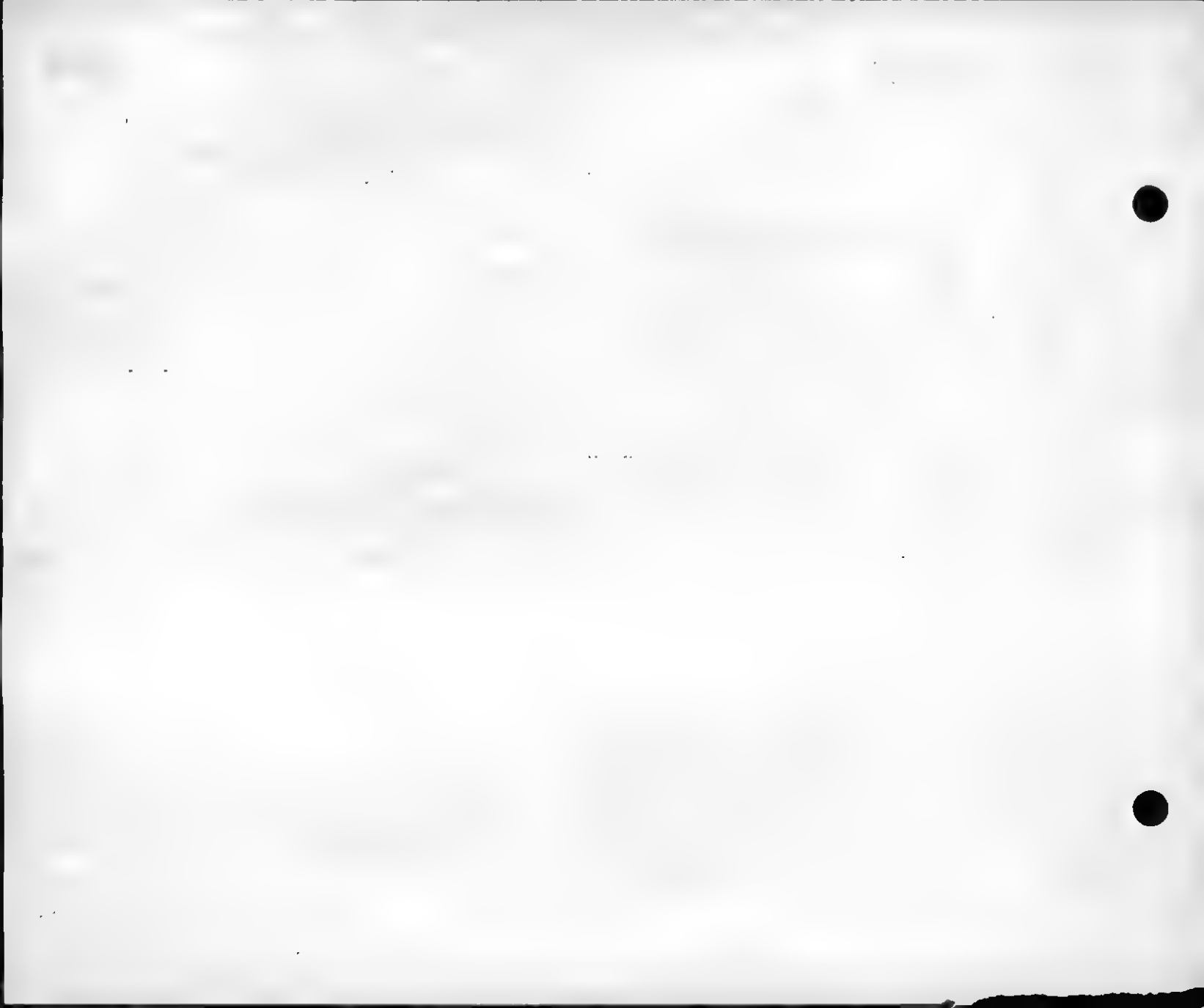
**04891**

**CERTIFICATE OF DEATH**

**04891**

1. PLACE OF DEATH <b>BALTIMORE</b> a. COUNTY <b>Catonsville</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>49yr9mth29dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belair, Md.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Philip</b> Middle <b>Shevcha</b> Last 4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>67</b>							
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-54-3423</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)		
21. I certify that (a) (this hospital) attended the deceased from <b>June 20, 1917</b> to <b>April 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 19, 1967</b> , and that death occurred at <b>10:35 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Morris Meiller</i> M.D.				22b. DATE SIGNED <b>4/19/67</b>		22c. PHYSICIAN'S NAME (Type) <b>MORRIS MEILLER, M.D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 21-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>new Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Old Frederick Rd. Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>Krause Funeral Home 1216 S Charles St #2230</b>				25a. REC'D BY REGISTRAR DATE <b>APR 24 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/67

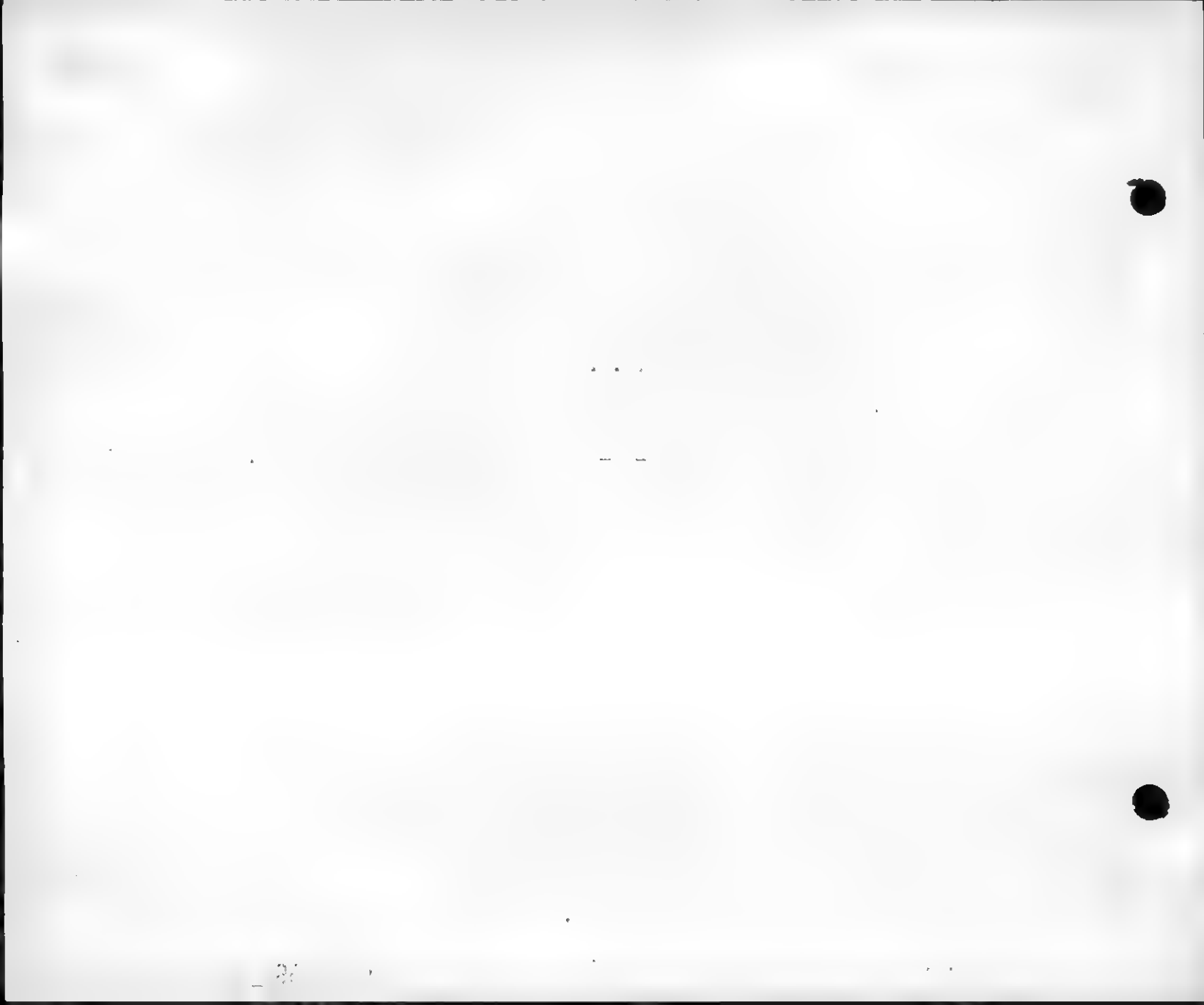
## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04892

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04892

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Balto.</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City, Md</u>		c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City, Md 21043</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21043 RIVER ROAD</u>			d STREET ADDRESS <u>River Road</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Albert</u> Last <u>Shipley</u>			4 DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/30/10</u>	9. AGE (In years last birthday) <u>56</u> Yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flour Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13 FATHER'S NAME <u>Albert Shipley</u>			14. MOTHER'S MAIDEN NAME <u>Carrie Dntell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-09-6145</u>		17 INFORMANT <u>Marion Shipley, Main St. Ellicott City, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis Liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James N. Frederick</u> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James N. Frederick MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1311 Francis Ave Balto. Md. 21222</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-28-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	
24 FUNERAL DIRECTOR <u>F.C. Higinbotham</u>		25a. REC'D BY REGISTRAR <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23d. LOCATION (City or Town) (County) (State) <u>Ellicott City, Md</u>		22. DATE SIGNED <u>4/24/67</u>			



TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

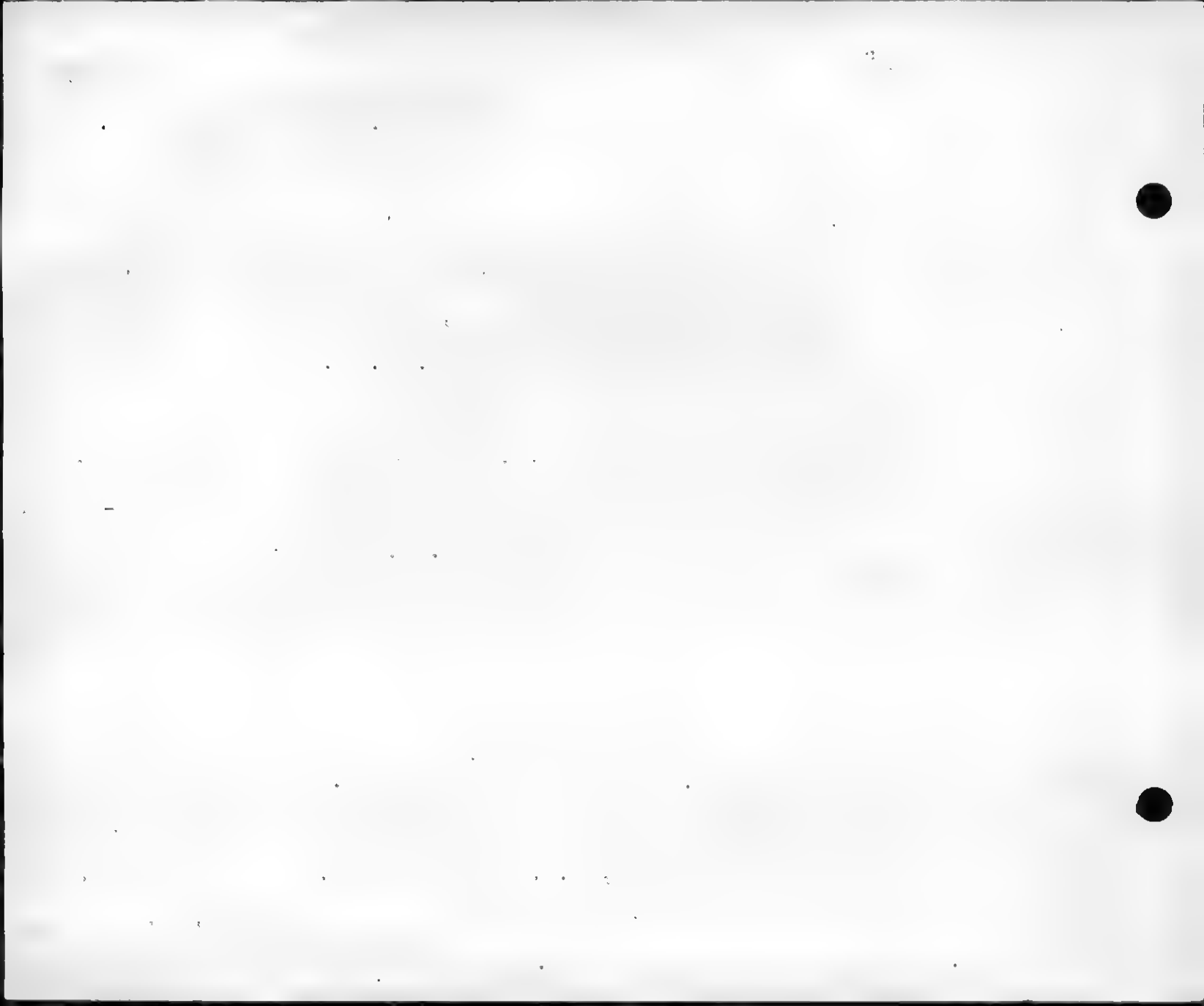
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04893

CERTIFICATE OF DEATH

04893

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>37 Hanover Road</u>		d. STREET ADDRESS <u>37 Hanover Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Shugars</u> Last <u>Shugars</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. AGE (In years and birthday) <u>88</u> yrs		10. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Shugars</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Frank M. Shugars</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO (c) <u>with cardiac decompensation</u> <u>Chronic Brain syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal ulcer</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5</u> , 19 <u>57</u> , to <u>Apr. 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr. 12</u> , 19 <u>67</u> , and that death occurred at <u>4A.</u> M. from causes on and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>4-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>48 Main St. Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 15, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Reisterstown, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>APR 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

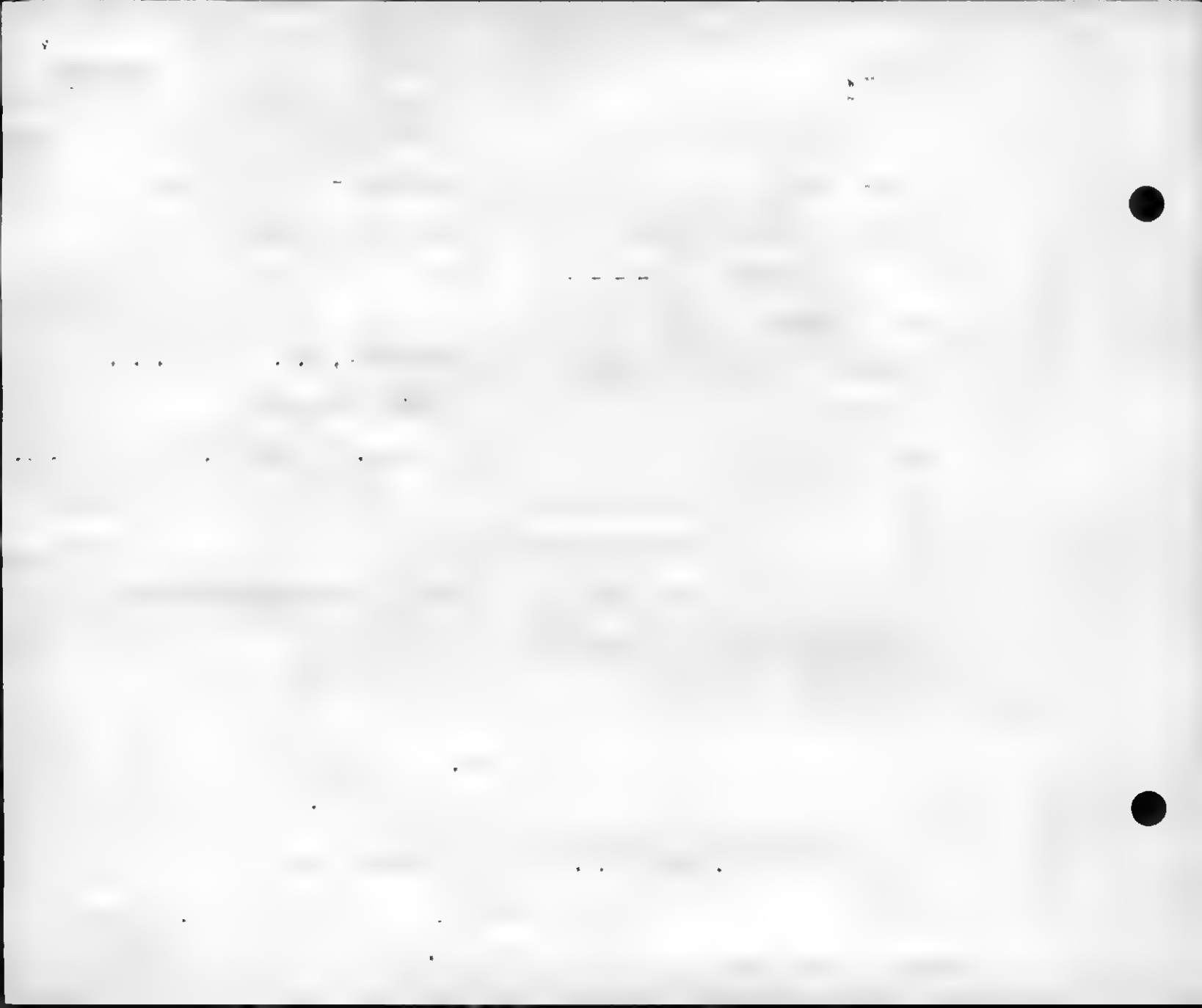
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04894

CERTIFICATE OF DEATH

04894

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>70 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1432 McCulloh Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLIFTON * - - - - SIMON</b>		4. DATE OF DEATH Month Day Year <b>April 21 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/20</b>
9. AGE (In years last birthday) <b>46</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>46</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bishopville, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tom Simon</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Hainesworth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>247 14 17 23</b>	
17. INFORMANT <b>Clinical Recs. VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>0021</b> DUE TO (b) <b>PULMONARY TUBERCULOSIS</b> (c) <b>TUBERCULOSIS OF ADRENALS AND GASTROINTESTINAL TRACT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>CHRONIC</b> <b>CHRONIC</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF LARYNX AND CARCINOMA OF TONSIL</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 10, 1967</b> to <b>April 21 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 21 1967</b> , and that death occurred at <b>7:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Alfonso A. Lopez</b>		22b. DATE SIGNED <b>4/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALFONSO A. LOPEZ, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home Baltimore, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>APR 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>U</b>		DATE <b>U</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

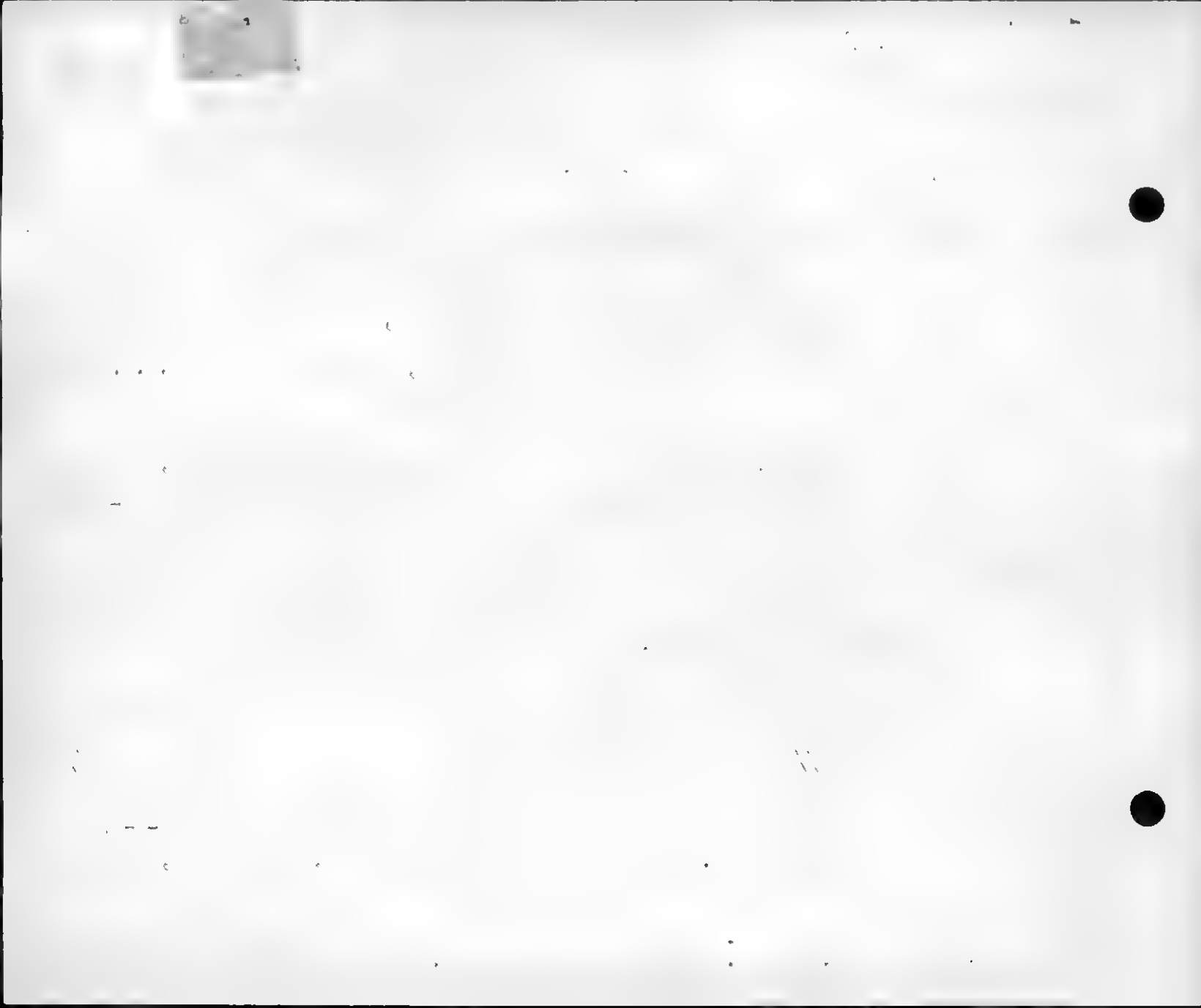
04895

**CERTIFICATE OF DEATH**

04895

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c LENGTH OF STAY in 1b <b>30 DAYS</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d STREET ADDRESS <b>3716 BARRINGTON ROAD</b>			
3 NAME OF DECEASED (Type or print) First <b>ULYSSES</b> Middle <b>SIMPSON</b> Last <b>SIMS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>19 67</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>NOVEMBER 3, 1896</b>		9 AGE (In years last birthday) <b>70</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a JSUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Club</b>		11 BIRTHPLACE (County & State, or foreign country) <b>TAMPA, FLORIDA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PETER SIMS</b>				14. MOTHER'S MAIDEN NAME <b>MARIA KING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO. <b>115 03 31 97</b>		17 INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>470X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 DAYS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBROVASCULAR ACCIDENT,</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 8, 19 67</b> , to <b>APRIL 7, 19 67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 7, 19 67</b> , and that death occurred at <b>405P</b> M, from causes and on the date stated above.							
22a SIGNATURE <i>Carmelita A. Cendana</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <b>4-9-67</b>	
22c PHYSICIAN'S NAME (Type) <b>CARMELITA A. CENDANA</b>				22d ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4/12/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>HERBERT E. NUTTER</b>				ADDRESS <b>FUNERAL HOME, 3035 W. NORTH AVE, BALTIMORE, MD.</b>		25a REC'D BY REGISTRAR <b>APR 11 1967</b>	
				25b REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

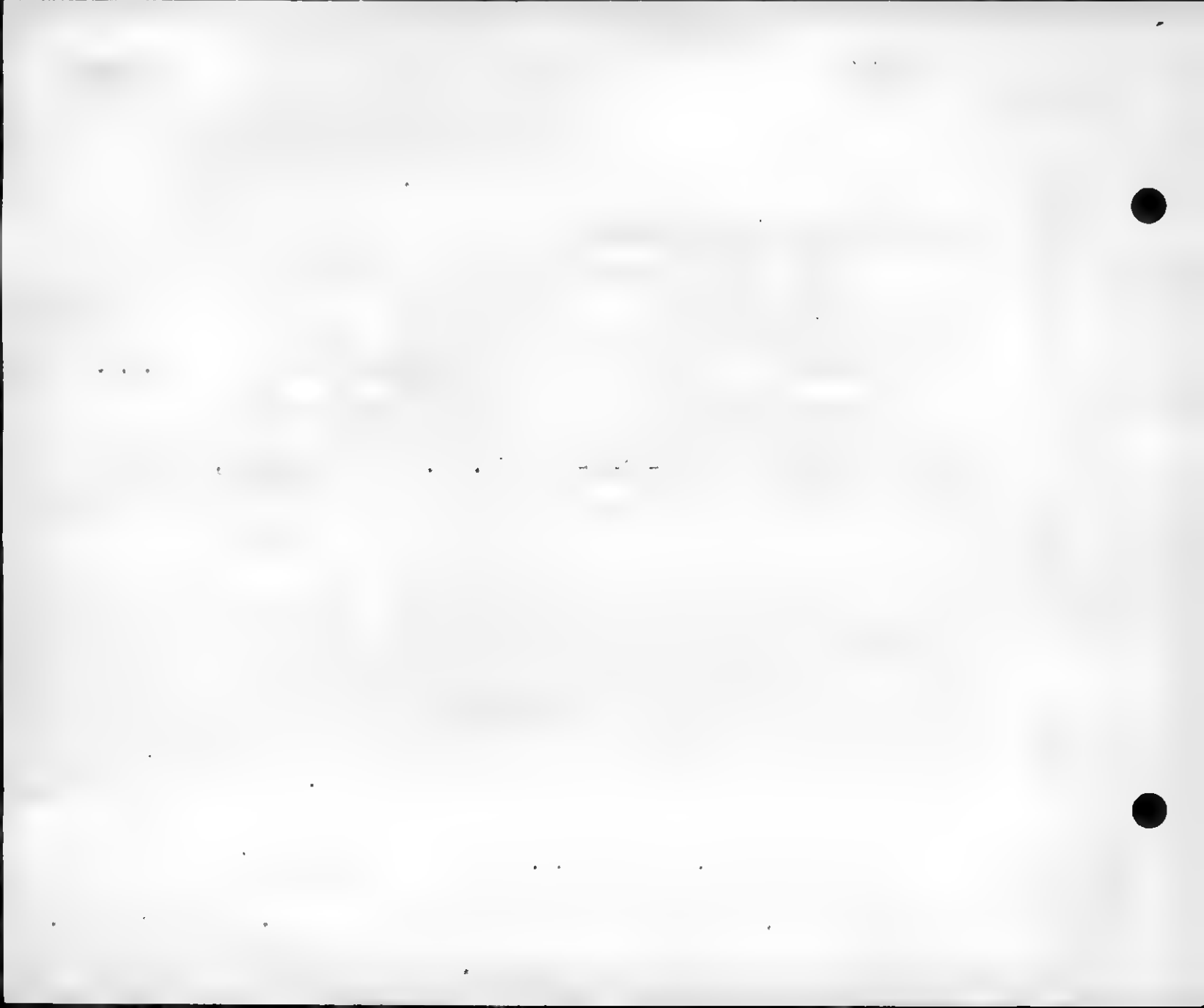
04896

**CERTIFICATE OF DEATH**

04896

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>30 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS _____			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ROY</u> Middle <u>ELMONT</u> Last <u>SKEGGS</u>				<b>4. DATE OF DEATH</b> Month <u>APRIL</u> Day <u>8</u> Year <u>1967</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/31/91</u>		<b>9. AGE</b> (in years last birthday) yrs <u>76</u>	<b>10. UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS</b> Hours _____ Mins _____	
<b>11a. US. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Police Chief</u>		<b>11b. KIND OF BUSINESS OR INDUSTRY</b> <u>Police</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Kempton, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Henry Skeggs</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Jay</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		<b>16. SOCIAL SECURITY NO</b> <u>218-10-84-84</u>		<b>17. INFORMANT</b> Address <u>Clin. Rec. VAH, Fort Howard, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter any one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> 4/6 EX DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town) (County) (State)</b> _____	
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <u>March 9, 1967</u> , to <u>April 8, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 8, 1967</u> , and that death occurred at <u>7:20 A.M.</u> from causes and on the date stated above							
<b>22a. SIGNATURE</b> <u>Isabelita Y. Cordoba, M.D.</u>				<b>22b. DATE SIGNED</b> <u>4/8/67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> _____	
<b>22d. ADDRESS</b> <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u>				<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Apr. 11, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pinegrove Cemetery</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Mt. Airy Carroll Md.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Clin. L. Molesworth</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 12 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	
<u>Clin Molesworth Funeral Home</u>				<u>Damascus, Md.</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04897

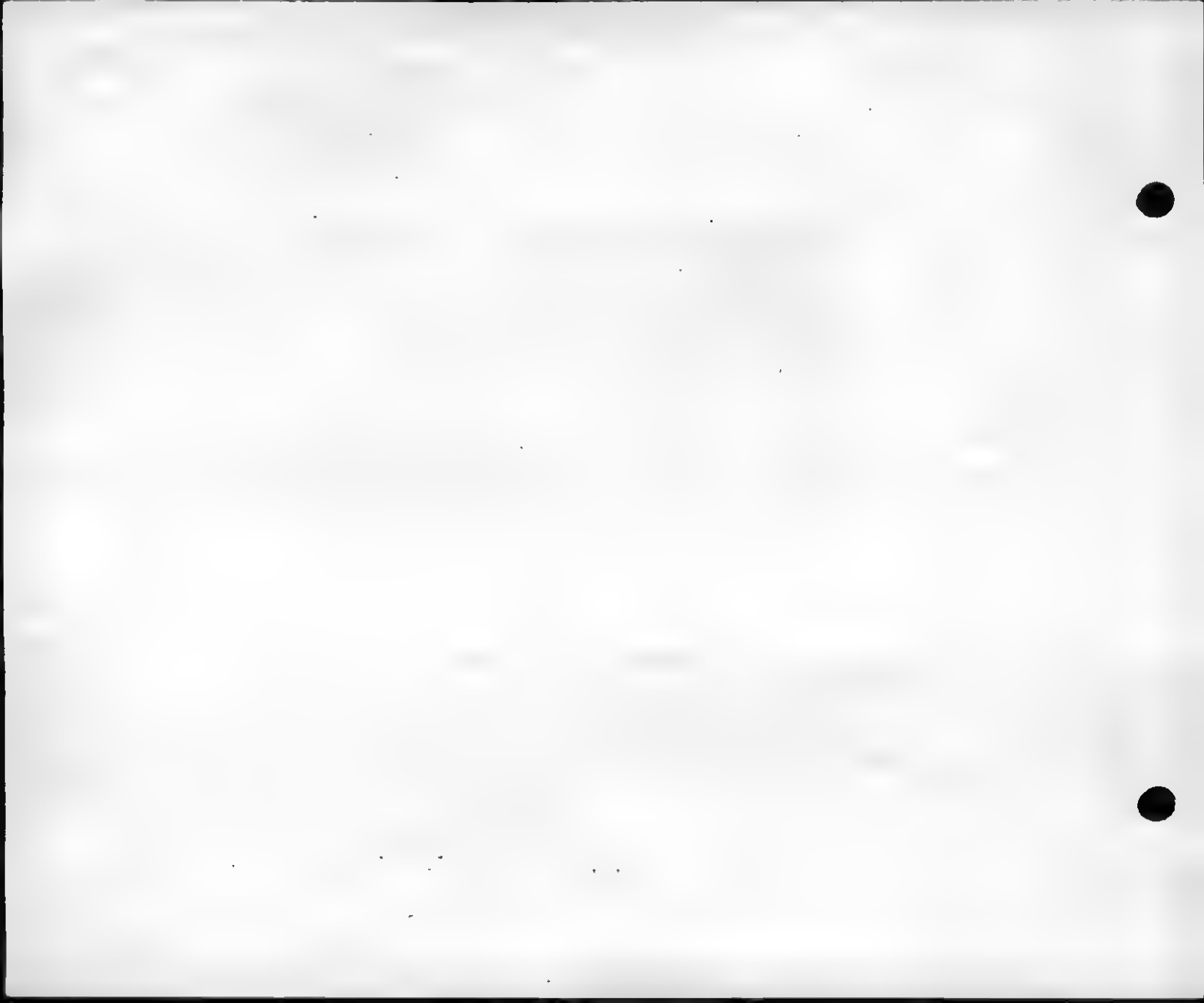
## CERTIFICATE OF DEATH

04897

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PARADISE NURSING HOME</b>		d. STREET ADDRESS <b>BALTIMORE - MD</b>	
3. NAME OF DECEASED (Type or print) <b>JONAS (John) SLIBURIS</b>		4. DATE OF DEATH <b>4 - 4 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-1883</b>
9. AGE (In years last birthday) <b>84</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LITH.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SLIBURIS</b>		14. MOTHER'S MAIDEN NAME <b>—</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>215-03-8681A</b>	
17. INFORMANT <b>MRS. ELIZABETH SLIBURIS</b>		Address <b>4714 Frederick Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>C. V. D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , to <b>4-4</b> , 1967, that (I) (we) last saw the deceased alive on <b>4-4</b> 1967, and that death occurred at <b>7:50 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Stanley Ankudas</b> M.D.		22b. DATE SIGNED <b>4.5.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stanley Ankudas, M.D.</b>		22d. ADDRESS <b>1101 Maiden Choice Lane #21229</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MONTICLOY CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD</b>
24. FUNERAL DIRECTOR <b>Thomas J. Kory Inc</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	
ADDRESS <b>1600 Heller St</b>		25b. REGISTRAR'S SIGNATURE <b>James H. Hodge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04898

CERTIFICATE OF DEATH

04898

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>321 STRATFORD RD</b>		d. STREET ADDRESS <b>321 STRATFORD RD</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSALIE</b> Middle <b>SLINGERLAND</b> Last <b>SLINGERLAND</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 25 1869</b>
9. AGE (In years last birthday) <b>97</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <b>LAUREL MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>ANDREW FLEASTER</b>	
14. MOTHER'S MAIDEN NAME <b>MARY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO		17. INFORMANT <b>ASHBY EUBANK</b> Address <b>321 STRATFORD RD #28</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular Disease</b> <b>40 yrs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>Sept.</b> , 19 <b>56</b> , to <b>April</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>March 29 1967</b> , and that death occurred at <b>10:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Leo J. Gaver</b> M.D.		22b. DATE SIGNED <b>4/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>		22d. ADDRESS <b>1 Mallory Hill Ave., Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill</b>	23d. LOCATION (City or town) (County) (State) <b>LAUREL MD</b>
24. FUNERAL DIRECTOR <b>E.S. Mac Nab</b> ADDRESS <b>301 Frederick Rd Balto 28 Md</b>		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



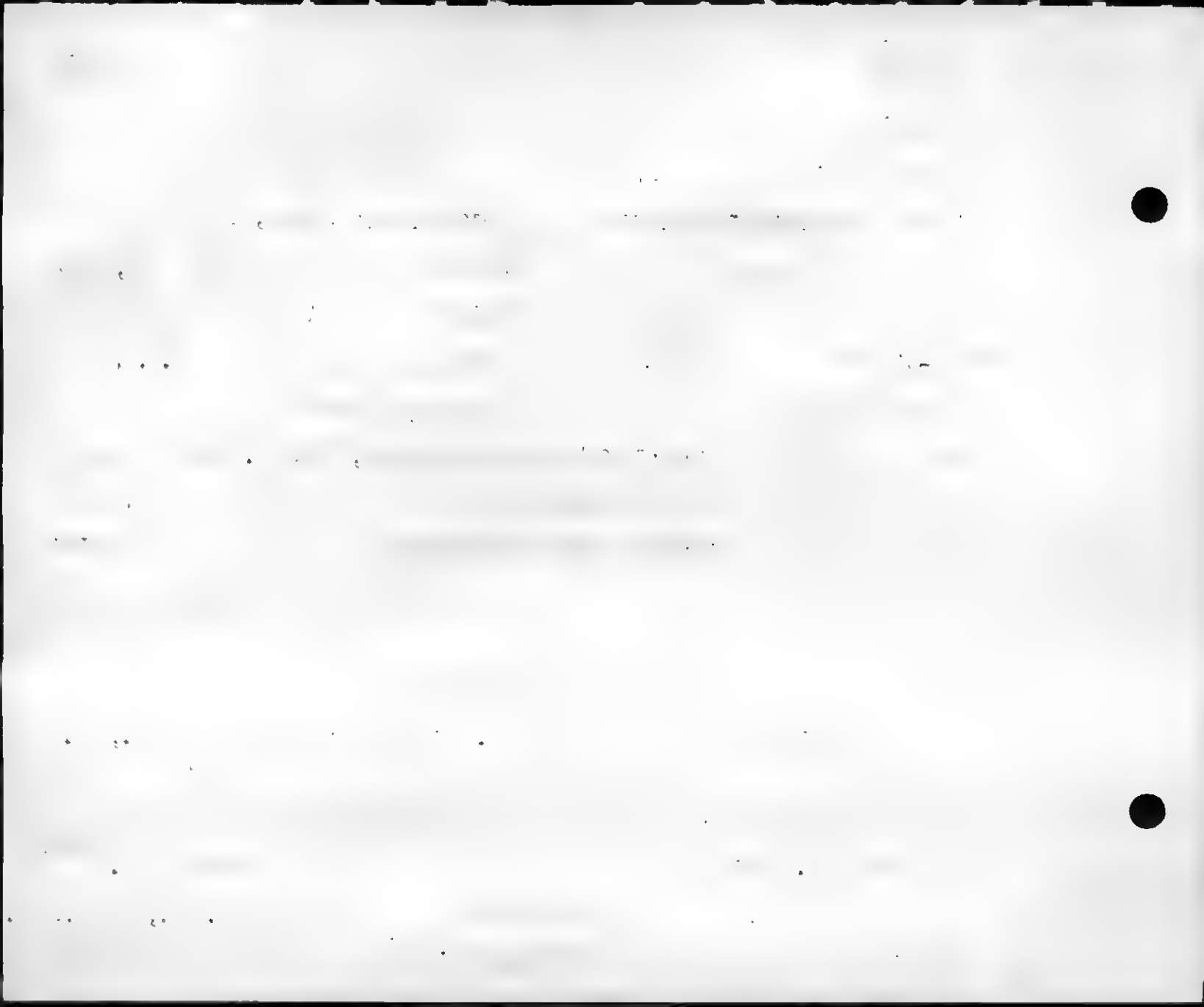
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

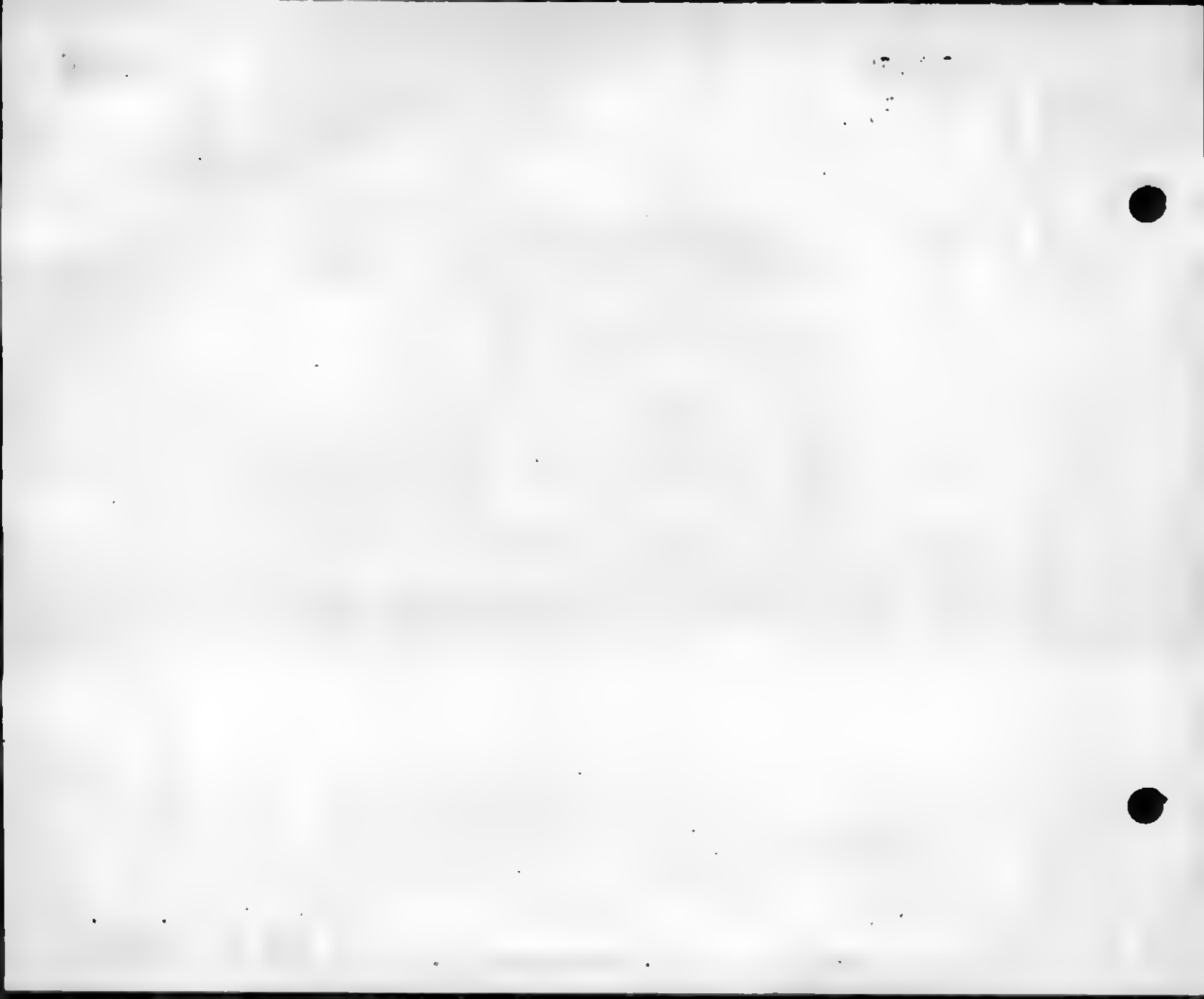
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>17 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3128 WILKENS AVENUE, 23</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER CLAY SMALLWOOD</b>		4. DATE OF DEATH Month Day Year <b>APRIL 29, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRIVER-SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM SMALLWOOD</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE IGLEHEART</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		18. SOCIAL SECURITY NO. <b>216 03 62 49</b>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FRACTURE LEFT HIP</b> DUE TO (b) <b>TERMINAL BRONCHIAL PNEUMONIA</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL ON FLOOR AND BROKE HIP</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>APRIL 12 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <b>VAH, FT. HOWARD</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FORT HOWARD, BALTO., MD.</b>		20f. (City or town) (County) (State) <b>FORT HOWARD, BALTO., MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>4/29/67</b>			
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, MD</b> Address (Street, city, town, or county) <b>DUNDALK, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>4300 OLD FRED. RD., BALTO., MD.</b>	
24. FUNERAL DIRECTOR <b>WALTERS FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>PRATT AND STRICKER STS. BALTIMORE, MARYLAND</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> DATE <b>MAY 2 1967</b>	





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04900						04900					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3401 FAIRVIEW Avenue</u>						d. STREET ADDRESS <u>3401 FAIRVIEW Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>WILLIS</u> Last <u>SMITH</u>						4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/3/1883</u>		9. AGE (in years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>  </u>						14. MOTHER'S MAIDEN NAME <u>  </u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-09-8709</u>		17. INFORMANT <u>MR ROBERT SMITH</u>				Address <u>322 E. Tenth St. Baltimore Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>OCTO 1952</u> to <u>4/13/67</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>4/12/67</u> , and that death occurred at <u>2017</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edwin L. Pierpont</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/13/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, MD.</u>						22d. ADDRESS <u>8204 LIBERTY RD - BALTO, 21209 MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town or county) (State) <u>3801 Frederick Ave. Balt. 21229</u>					
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

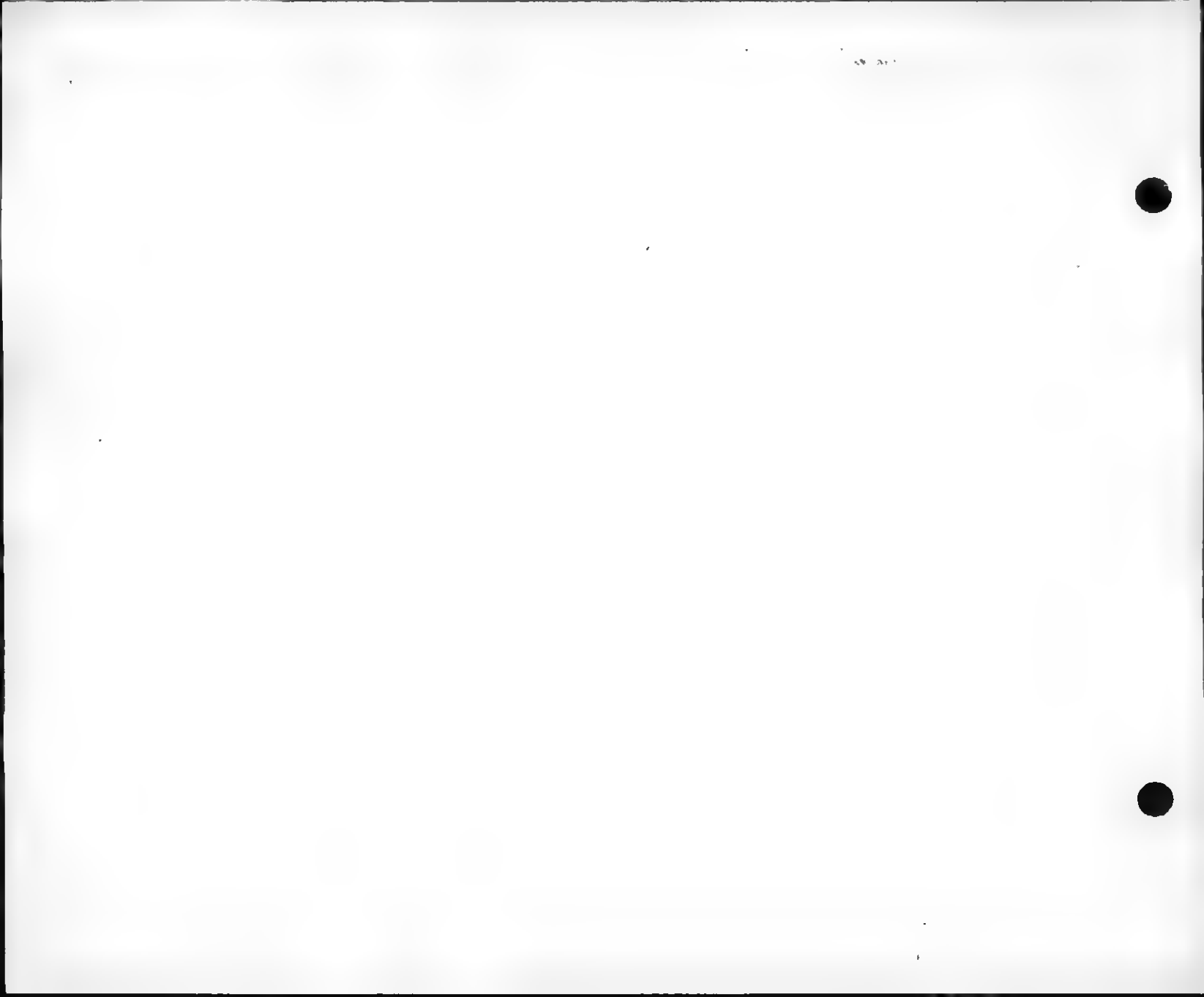
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #8 & 9 Film #1198 5/1/67 ps

04902

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04902

1 PLACE OF DEATH a COUNTY <b>Balto.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Balto.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c LENGTH OF STAY in Md <b>D.O.A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hosp.</b>		d STREET ADDRESS <b>8521 Glenn Michael Lane</b>	
3 NAME OF DECEASED (Type or print) <b>Joseph A. Sollod</b>		4 DATE OF DEATH Month <b>Apr.</b> Day <b>5</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11/10/06</b> AGE (In years last birthday) <b>60 79</b> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11 BIRTHPLACE (State or foreign country) <b>Russia</b>
13. FATHER'S NAME <b>Hyman Sollod</b>		14. MOTHER'S MAIDEN NAME <b>Chia ?</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>216-10-2182</b>	17 INFORMANT <b>Mrs. Anna Sollod, 8521 Glenn Michael Lane,</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Rheumatic Hypertensive Arteriosclerotic C-V Dis.</b> <b>416 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Hour a.m. <b>none</b> Month <b>19</b> Day Year		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
6 Hanover Rd. <b>Baltimore, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>4-5-67</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>April 6, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>ROSEDALE</b>	23d LOCATION (City or Town) (County) (State) <b>BALTO MD</b>
24 FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, P.O. Box 65, Garrison, Md.</b>		25a RECD BY REGISTRAR <b>APR 7 1967</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04902

CERTIFICATE OF DEATH

04903

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisters town</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>				d. STREET ADDRESS <u>Rt. 2 Box 353</u>			
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Spurrer</u>				4 DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/26/97</u>	9 AGE (In years last birthday) <u>69</u> yrs	f. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Spurrer Anthony</u>				14. MOTHER'S MAIDEN NAME <u>Krammer</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16 SOCIAL SECURITY NO <u>215-34-8600</u>		17. INFORMANT <u>Hospital chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Emphysema</u> 424.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal 2° Chronic lung disease</u> DUE TO (c) <u>Generalized Arteriosclerotic Calcification disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>3-31</u> , 19 <u>67</u> , to <u>4-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> , and that death occurred at <u>6:50am</u> , from causes and on the date stated above							
22a. SIGNATURE <u>J. Simon</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-3-67</u>	
22c. PHYSICIAN'S NAME (Type)				22a. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMET.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR <u>WALTERS FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>STRICKER</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 21 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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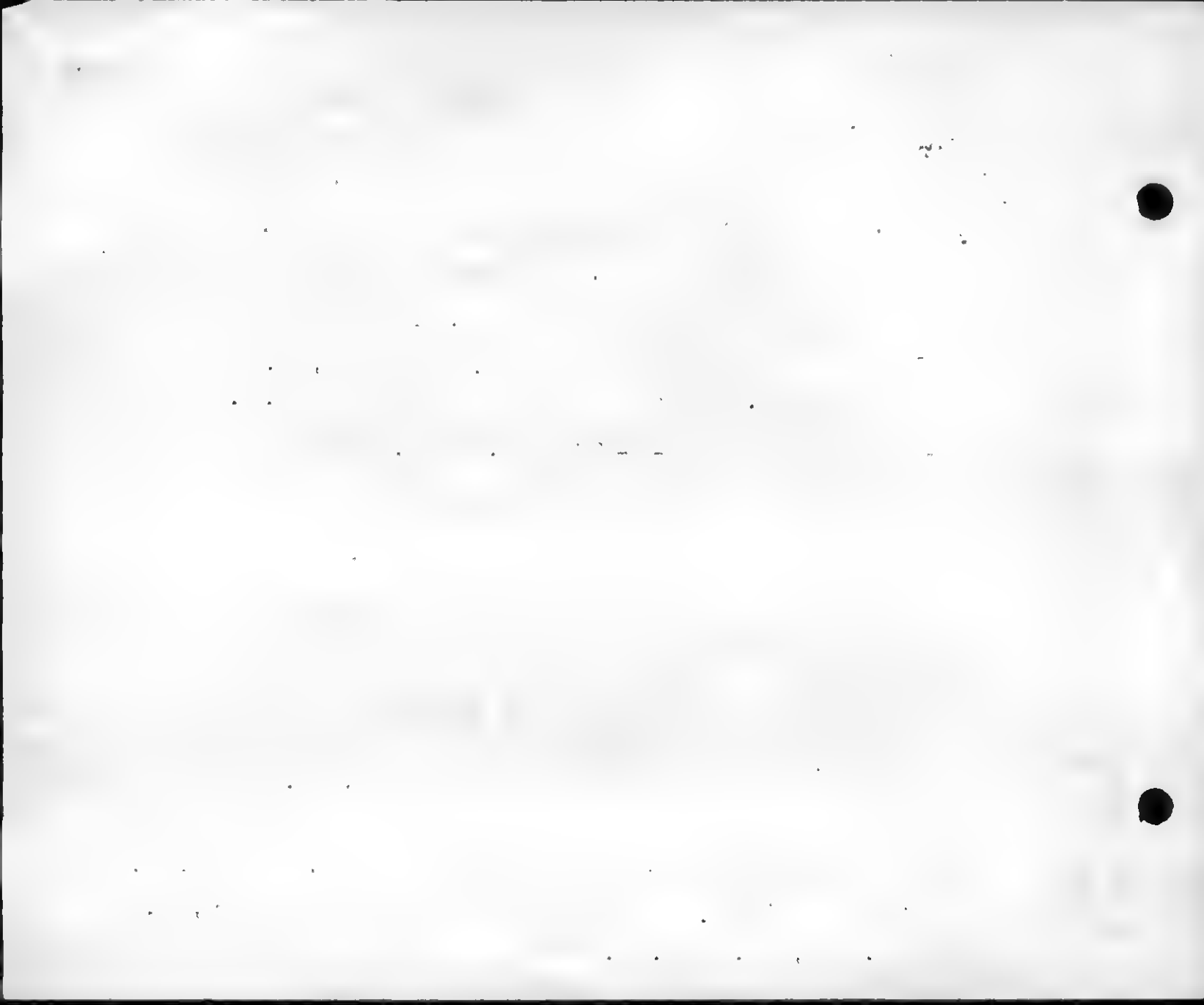
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04903

CERTIFICATE OF DEATH

04904

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN <b>_____</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1571 Stonewood Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Steadman</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26 1910</b>	9. AGE (In years last birthday) <b>57</b> yrs	IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b>		IF UNDER 24 HRS Hours <b>_____</b> Min <b>_____</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Marvelite Paint Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward V. Steadman</b>				14. MOTHER'S MAIDEN NAME <b>Mary. E. Cain</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-10-6325</b>		17. INFORMANT <b>Mrs. Mary R. Steadman</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of head of pancreas.</b> DUE TO (c) <b>_____</b>							INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple small pulmonary emboli.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>_____</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 17, 19 67</b> , to <b>April 17 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 17 1967</b> , and that death occurred at <b>7:10 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>N.S. Cockburn, M.D.</b>				22b. DATE SIGNED <b>April 18, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>N.S. Cockburn, M.D.</b>	
22d. ADDRESS <b>6620 York Rd. Baltimore, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/21/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>APR 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04904

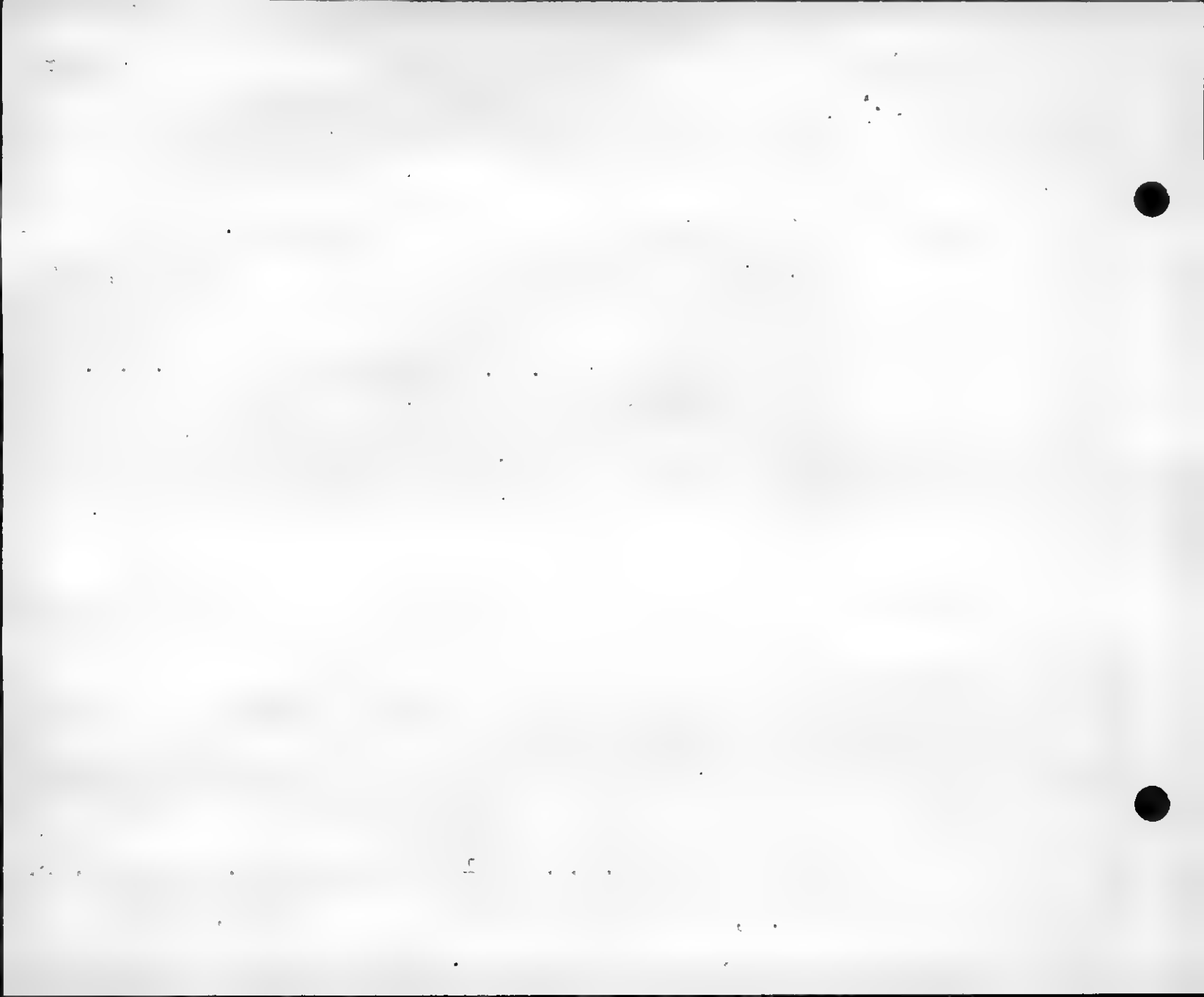
CERTIFICATE OF DEATH

04905

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) / o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House in the Pines Nursing Home</b>		d. STREET ADDRESS <b>158 Stonecroft Apts.</b>	
3. NAME OF DECEASED (Type or print) <b>William Perry Stedman</b>		4. DATE OF DEATH <b>April 3, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1881</b>
9. AGE (In years last birthday) <b>85 84 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Life Ins. Co.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Waterbury, Conn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Taylor Stedman</b>		14. MOTHER'S MAIDEN NAME <b>Dobey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mr. Henry T. Stedman</b>		Address <b>Severna Park Maryland</b> <b>30 Boone Trail</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>1950</b> , 19 to <b>April 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1967</b> , and that death occurred at <b>5:20 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Nesbitt Jr.</b>		22b. DATE SIGNED <b>4-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Nesbitt Jr. M.D.</b>		22d. ADDRESS <b>1009 Frederick Rd. Catonsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Apr. 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 6 1967</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

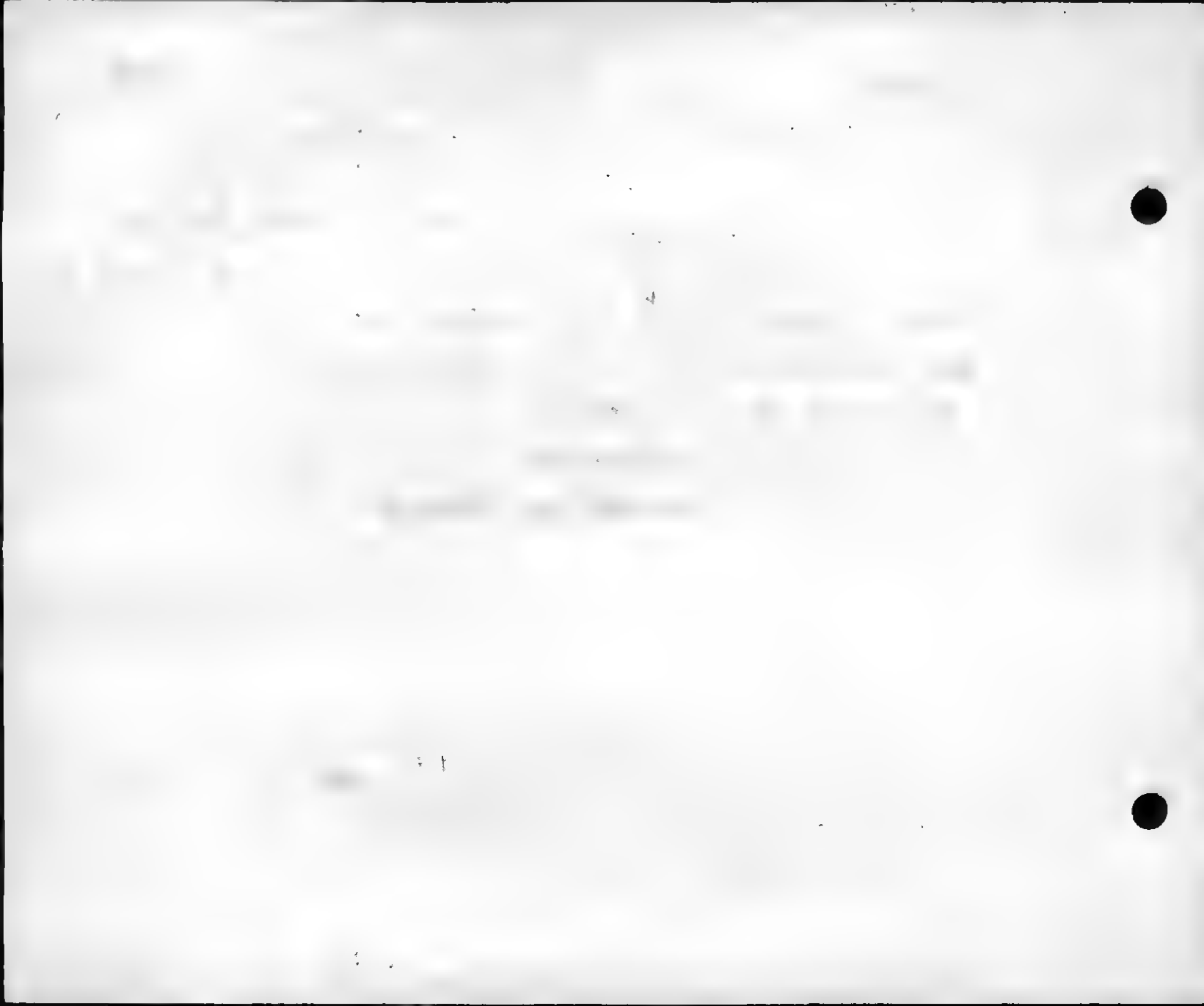
04905

04906

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>          </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN IT <u>9 day</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore city</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'to, give street address) <u>Greater Baltimore Med Center</u>				d. STREET ADDRESS <u>6010 Glen Oak Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Gerhard</u> First <u>L</u> Middle <u>Steep</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1967</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>10-29-94</u>	
9 AGE (In years lost birthday) <u>72</u> yrs		10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wren's Watch Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>          </u>		9 AGE (In years lost birthday) <u>72</u> yrs	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>Sigmund M. Steen</u>				14. MOTHER'S MAIDEN NAME <u>          </u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>          </u> (If yes give war or dates of service) <u>217-05-7923</u>				17 INFORMANT <u>J. J. Clark</u> Address <u>          </u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hemophysis, massive</u> <u>7831</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>          </u> DUE TO (c) <u>          </u>							INTERVAL BETWEEN ONSET AND DEATH <u>          </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>          </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>          </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>          </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>          </u>		20f. (City or town) (County) (State) <u>          </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> to <u>4-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> , 19 <u>67</u> , and that death occurred at <u>9:46</u> p.m., from causes and on the date stated above.							
22a. SIGNATURE <u>M. Margaret Zassenhaus</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>4-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARGRET ZASSENHAUS</u>				22d. ADDRESS <u>BELLON AVE 7028 BALTIMORE 12, MD</u>			
23a. BURIAL CREMATION, REMAINS (Specify)		23b. DATE THEREOF <u>4/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>          </u>		23d. LOCATION (City or town) (County) (State) <u>Balti</u>	
24. FUNERAL DIRECTOR <u>W. W. Steen</u> <u>6067 Hayford Rd</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>          </u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 2 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04906

## CERTIFICATE OF DEATH

04901

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>314 Riverside Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u> d. STREET ADDRESS <u>314 Riverside Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Irene E. Stephens</u>		<b>4. DEATH</b> OF DEATH Month Day Year <u>April 29, 1967</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct, 1888</u> <b>9. AGE (in years last birthday)</b> <u>78</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Never worked</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>George Morris</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Jeanette</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mr. Boyde H. Stephens</u> <b>Address</b> <u>same address</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Circulatory failure</u> DUE TO (b) <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Generalized arteriosclerosis = Hypertensive CVD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Severe.</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>few minutes</u> <u>few minutes</u> <u>several hours</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>January 7, 1967</u> <b>to</b> <u>April 29, 1967</u> <b>that (I) (the) last saw the deceased alive on</b> <u>April 26, 1967</u> <b>and that death occurred at</b> <u>11:30</u> <b>A.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Eugene C. Baumann</u> <b>M.D.</b>		<b>22b. DATE SIGNED</b> <u>5-2-67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>EUGENE C. BAUMANN</u>			
<b>22d. ADDRESS</b> <u>43 EASTERN AVE. BALTIMORE, Md 21221</u>		<b>22e. REC'D BY REGISTRAR</b> <u>Charles Jones</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5/3/1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore, Md.</u>		<b>23e. (State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. F. Ticken &amp; Son</u> <b>ADDRESS</b> <u>Baltimore, Md.</u>							

AND STATE DEPARTMENT

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

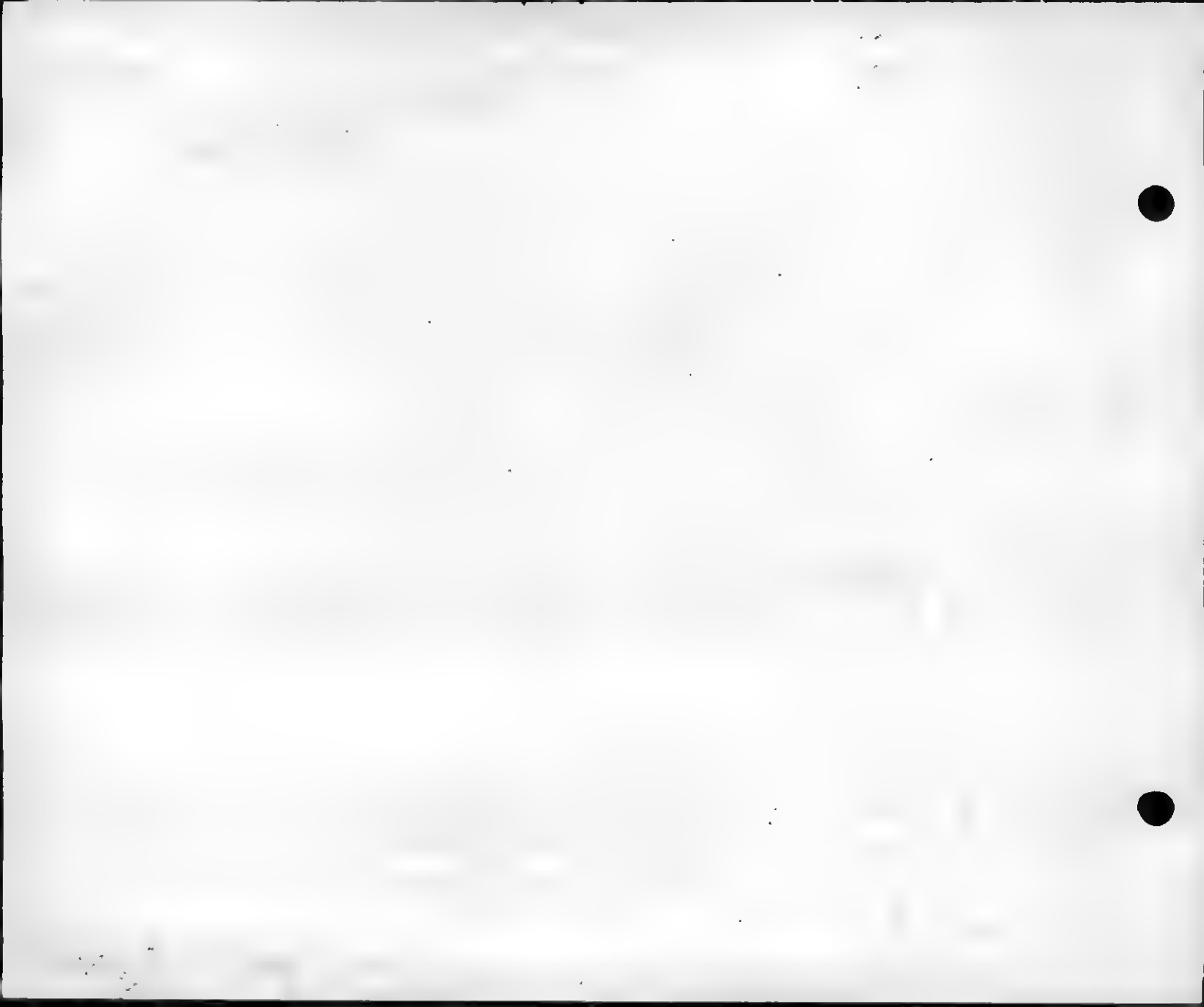
04907

## CERTIFICATE OF DEATH

04907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jockessville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>				d. STREET ADDRESS <u>421 Warren Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bruce</u> Middle <u>T</u> Last <u>Strailman</u>				4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-29-1898</u>	
9. AGE (In years last birthday) <u>68</u> Yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (County & State or foreign country) <u>Fredricksburg, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Charles Strailman</u>			
14. MOTHER'S MAIDEN NAME <u>Lidia E. Baer</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>213 34 9279</u>		17. INFORMANT Address <u>Mr. Bruchey 785 Marina Cross Rd</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO <u>arteriosclerotic cardiac vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> , 19 <u>59</u> , to <u>4-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>67</u> , and that death occurred at <u>4</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>John J. Gould</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>JOHN J. GOULD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-29-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Aethel cm</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>Thomas J. Henry, Inc 1607 Hollins st</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

04908

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

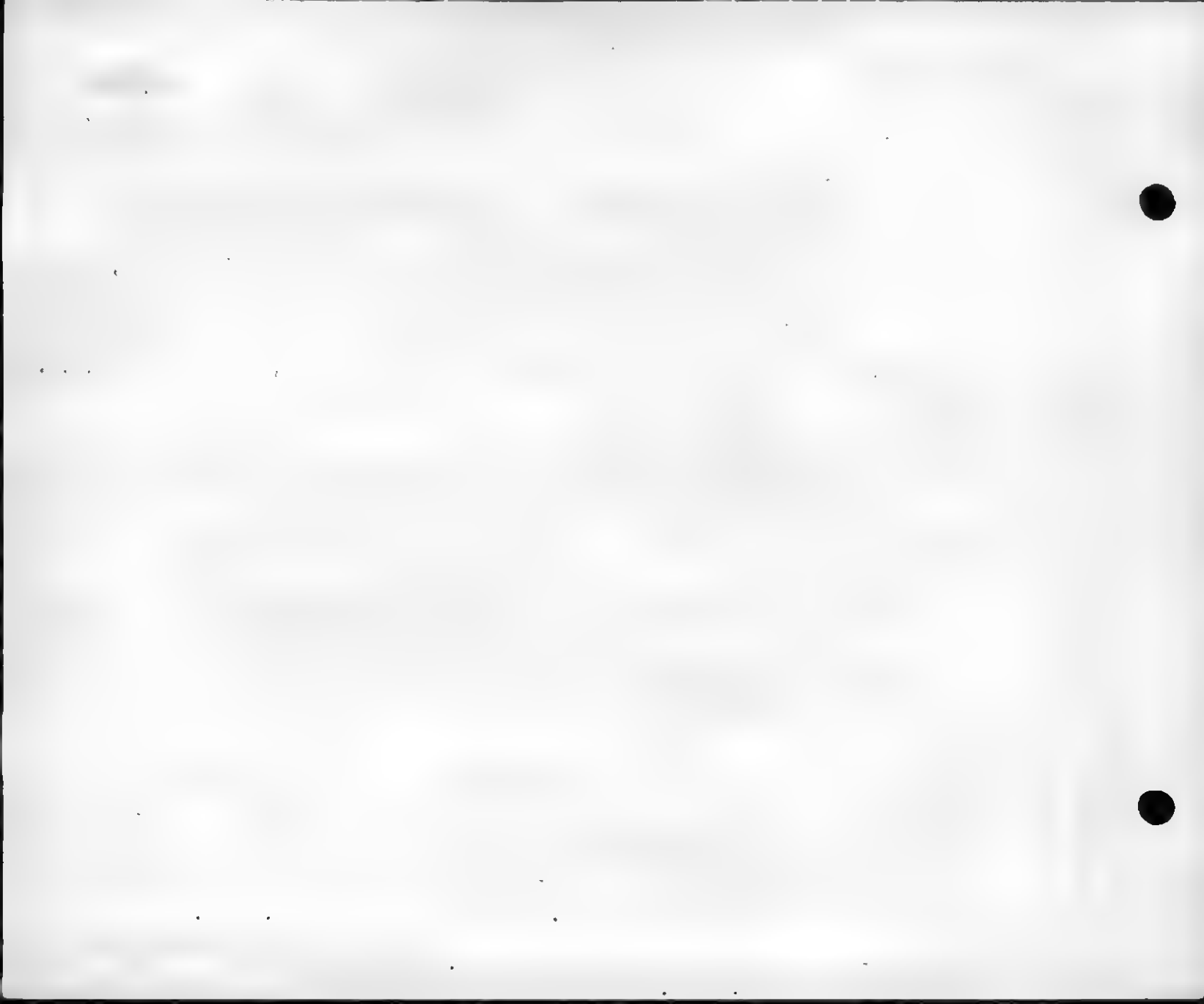
Item #2a, b, c & d from Form 10-108 4/25/67

CERTIFICATE OF DEATH

04908

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> Va. b. COUNTY <b>Baltimore</b> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Ruxton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>St. Gabriel's Home ... Hilton Avenue 1300 Carrollton</b> IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Gretchen</b> Middle <b>Gabrielle</b> Last <b>STREETT</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1967</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-51</b>	9. AGE (In years day b r h day) yts <b>16</b>	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>David Corbin Streett</b>				14. MOTHER'S MAIDEN NAME <b>Hildegard Volkmann</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no --</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO <b>Cerebral hypodosis (Batten's disease)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>13 yrs</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>13 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Institutionalization due to spastic quadriplegia</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (s) (this hospital) attended the deceased from <b>April 19, 1963</b> , to <b>April 15, 1967</b> , that (s) (we) last saw the deceased alive on <b>April 15, 1967</b> , and that death occurred at <b>10:25 PM</b> , from causes and on the date stated above.				
22a. SIGNATURE <b>Richard A. Jones</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>15 April 67</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones</b>		
22d. ADDRESS <b>Rosewood State Hosp.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>		
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

Balto., Md. 21212



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

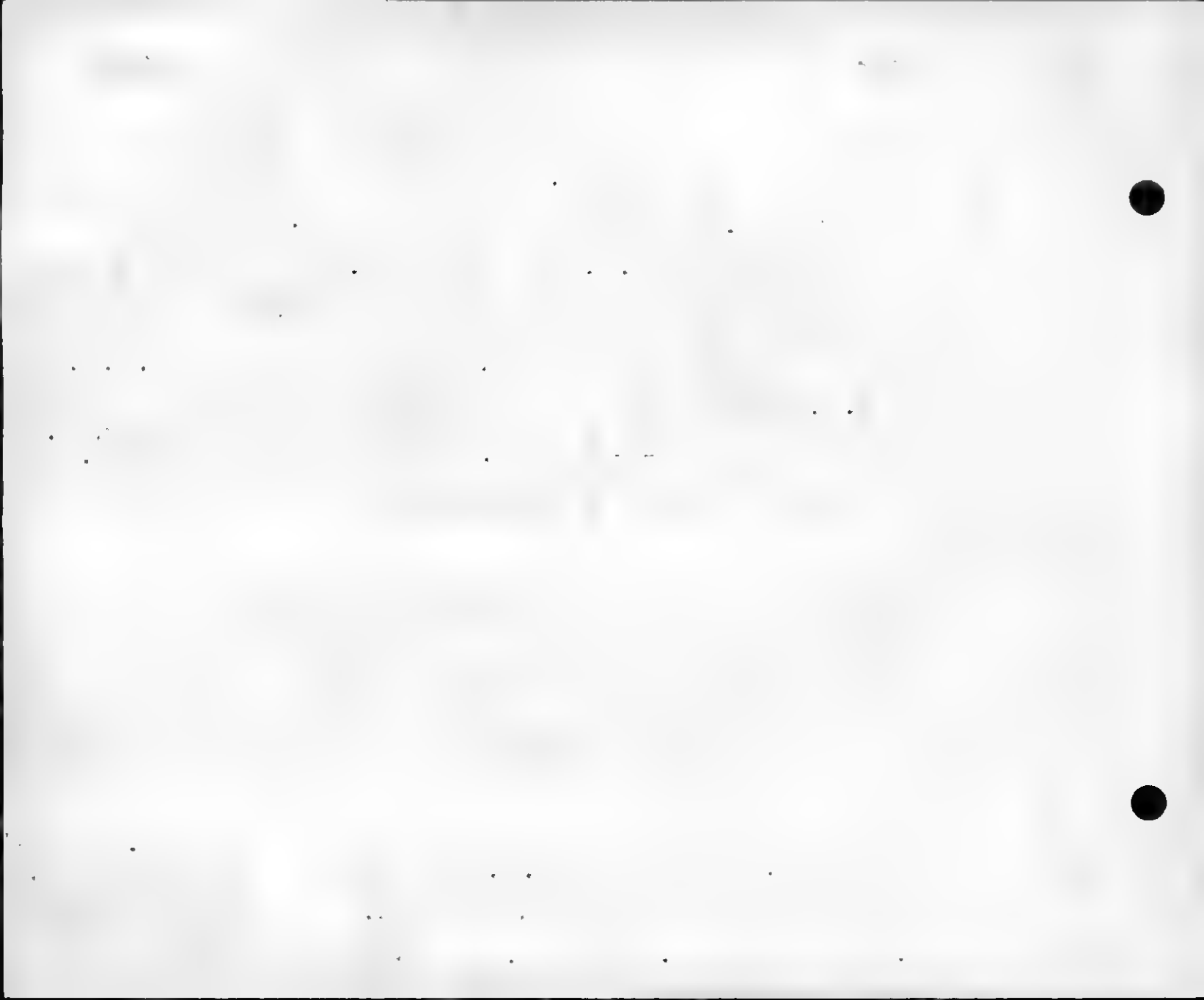
FOR STATE  
HEALTH DEPT.

04903

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #8 & 9 Film #1387 11/18/67 pc  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04909

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN IT <b>31 Yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1929 Crafton Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>John W. F. Sudbrink Sr.</b>				4. DATE OF DEATH Month Day Year <b>April 8 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/16/82 1885</b>	
9. AGE (In years last birthday) <b>81 1/2</b>		10. UNDER 1 YEAR Months Days <b>11 11 11</b>		11. UNDER 24 HRS Hours Min <b>11 11</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co. Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John W. H. Sudbrink</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>213-09-0457</b>			
17. INFORMANT (Wife) <b>Mrs. Jennie Sudbrink</b>				Address <b>Dundalk, Md. 1929 Crafton Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>H-S-C-V-DISEASE</b> 4021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) (County) (State) <b>None</b>				20g. (City or town) (County) (State) <b>None</b>			
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Melvin B. Davis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, Md.</b>				22. DATE SIGNED <b>4/11/67</b>			
Address (Street, city, town, or county) <b>6800 Morningside Rd.</b>							
23a. BURIAL (Cremation or removal) <b>Burial</b>		23b. DATE THEREOF <b>4/12/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Bel Air Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04910

04910

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>4406 WENTWORTH ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARIAN VIRGINIA SUTER</b>		4. DATE OF DEATH Month Day Year <b>4 22 1967</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/43</b>
9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO., MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN FREDERICK LUTZ</b>		14. MOTHER'S MAIDEN NAME <b>CASHELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-42-6700</b>	
17. INFORMANT <b>PHS HISTORY</b>		Address <b>Henry B. Suter - 4406 Wentworth Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant tumor (Probably lymphoma)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>with wide spread metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-12</b> , 19 <b>67</b> , to <b>4-22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-22-</b> 19 <b>67</b> , and that death occurred at <b>5</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Kuwilsky</b>		22b. DATE SIGNED <b>4-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dora C Kuwilsky MD</b>		22d. ADDRESS <b>Greater Baltimore Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-24-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>ELLSWORTH ARMAGOST</b>		25a. REC'D BY REGISTRAR <b>4600 Lib. Hghts. Ave</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>APR 24 1967</b>	

MEDICAL CERTIFICATION

[illegible]

**FOR STATE  
HEALTH-DEPT.**

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

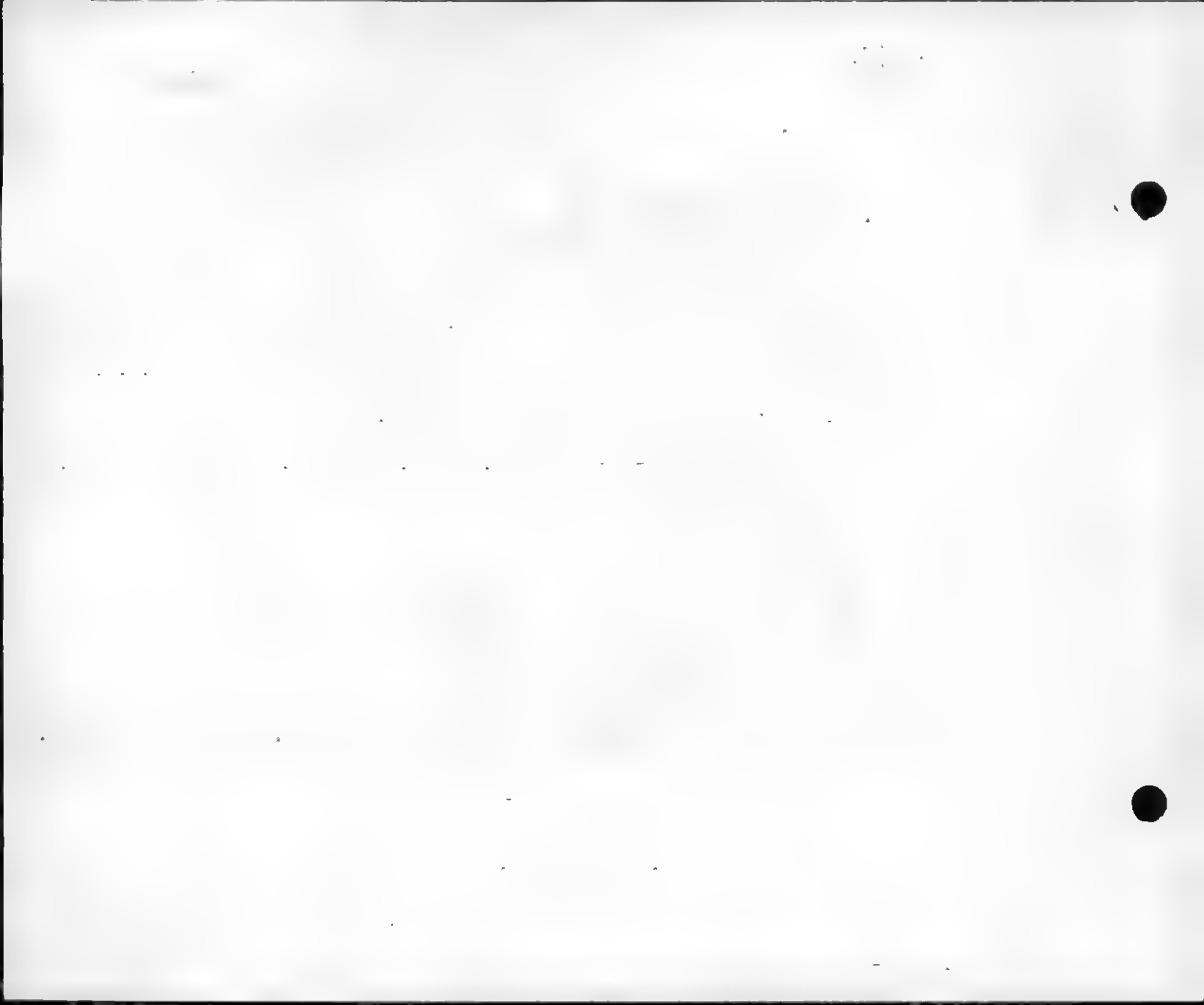
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04911

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04911

1 PLACE OF DEATH a. COUNTY <b>Baltimore,</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>Hours</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>7603 Perring Terrace</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Susan Victoria Switzer</b>		4 DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 6, 1943</b>
9 AGE (In years last birthday) yrs <b>24</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>	10b KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Aubrey J. Switzer</b>		14 MOTHER'S MAIDEN NAME <b>Audrey M. Carson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>217-40-1360</b>	
17 INFORMANT <b>Mr. &amp; Mrs. Aubrey J. Switzer</b>		Address <b>7603 Perring Terr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shotgun wound of abdomen</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>shot self in abdomen</b>	
20c TIME OF INJURY Month, Day, Year <b>4/15/67; 4:15 PM</b>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>home</b>
20f (City or town) <b>Baltimore, Md.</b>		20g (County) (State) <b>Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner V. Spitz</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner V. Spitz, M. D.</b>		22 DATE SIGNED <b>April, 15, 1967</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/18/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>
23d LOCATION (City or Town) <b>Baltimore, Maryland</b>		23e LOCATION (County) (State) <b>Baltimore, Maryland 21234</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>		25a REC'D BY REGISTRAR <b>APR 20 1967</b>	
25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c REGISTRAR'S NAME <b>[Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04912

CERTIFICATE OF DEATH

04912

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>AMBROSE</b> Last <b>TALBOTT</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/26/91</b>
9 AGE (n years last birthday) yrs <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Talbott</b>		14. MOTHER'S MAIDEN NAME <b>Ida L. Miller</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>215 32 39 21</b>	
17. INFORMANT <b>Clinical Rcds, VA Hospital, Ft Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> 471A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOPNEUMONIA</b> DUE TO (c)			INTERVA. BETWEEN DEATH <b>RECENT</b> <b>RECENT</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>3/31</b> , 19 <b>67</b> , to <b>April 2</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>4/2</b> , 19 <b>67</b> , and that death occurred at <b>9:05</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED <b>4/3/67</b>	22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>
22d. ADDRESS <b>VA Hospital, Fort Howard, Maryland</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>257 S. CONKLING ST. BALTIMORE, MD.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

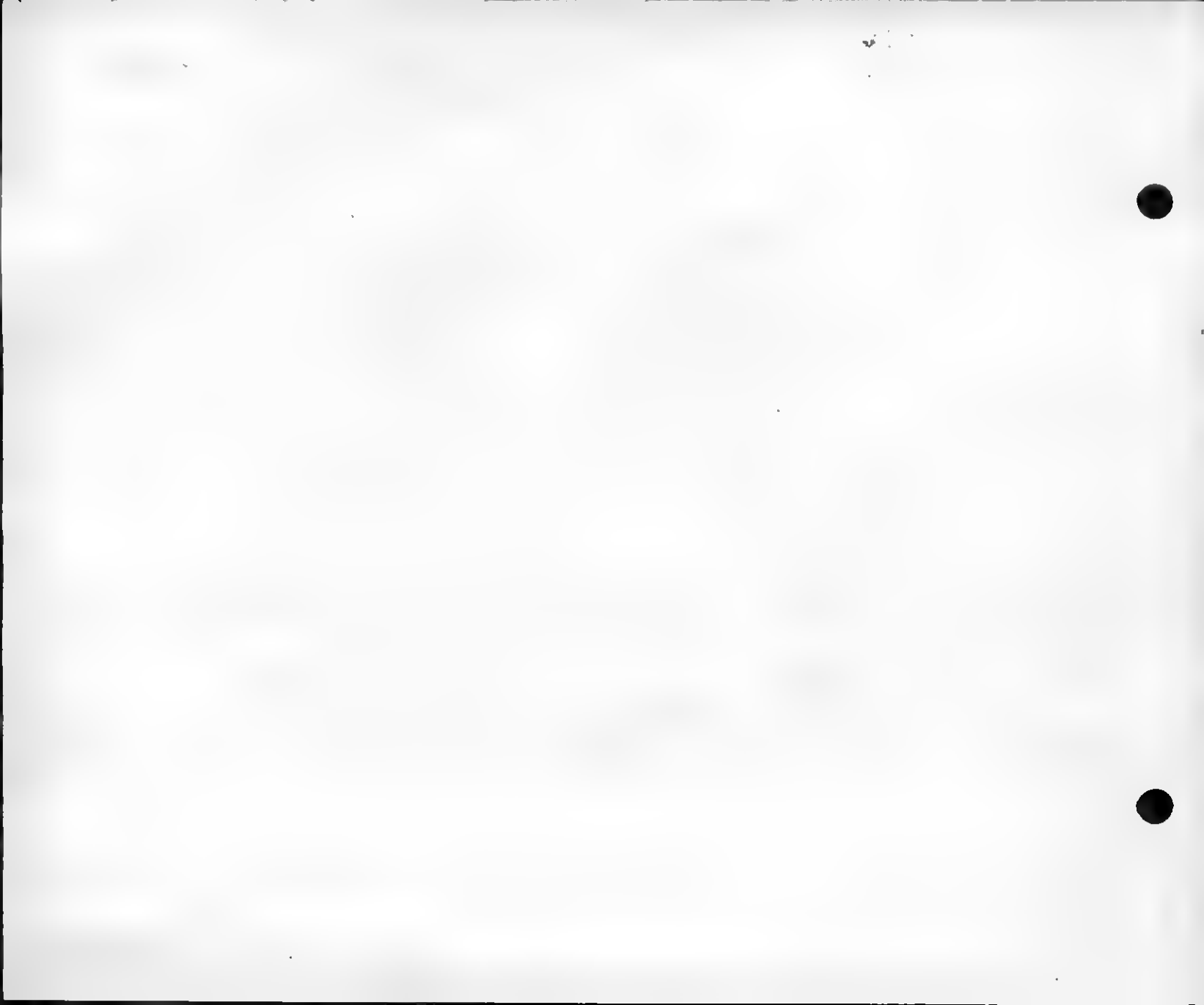
04913

CERTIFICATE OF DEATH

04913

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in 1b <u>37 yr. 2 mo 17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE Hospital</u>				d. STREET ADDRESS <u>1204 St Paul Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mae Templeman Taylor</u>				4. DATE OF DEATH Month Day Year <u>April 12 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1904</u>	
9. AGE (In years last birthday) <u>63 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robertson Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Mae Templeman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Records, SPRING GROVE STATE Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: <u>193X</u> IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c) _____							INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of the liver.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 12, 1964</u> , to <u>APRIL 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1967</u> , and that death occurred at <u>2:00 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>S. E. [Signature] M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Evelio H. Felipe M.D.</u>				22d. ADDRESS <u>SPRING GROVE STATE Hospital Baltimore, Maryland 21238</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chenwood Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Norfolk Va</u>	
24. FUNERAL DIRECTOR <u>William [Signature]</u>				25a. REC'D BY REGISTRAR DATE <u>APR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

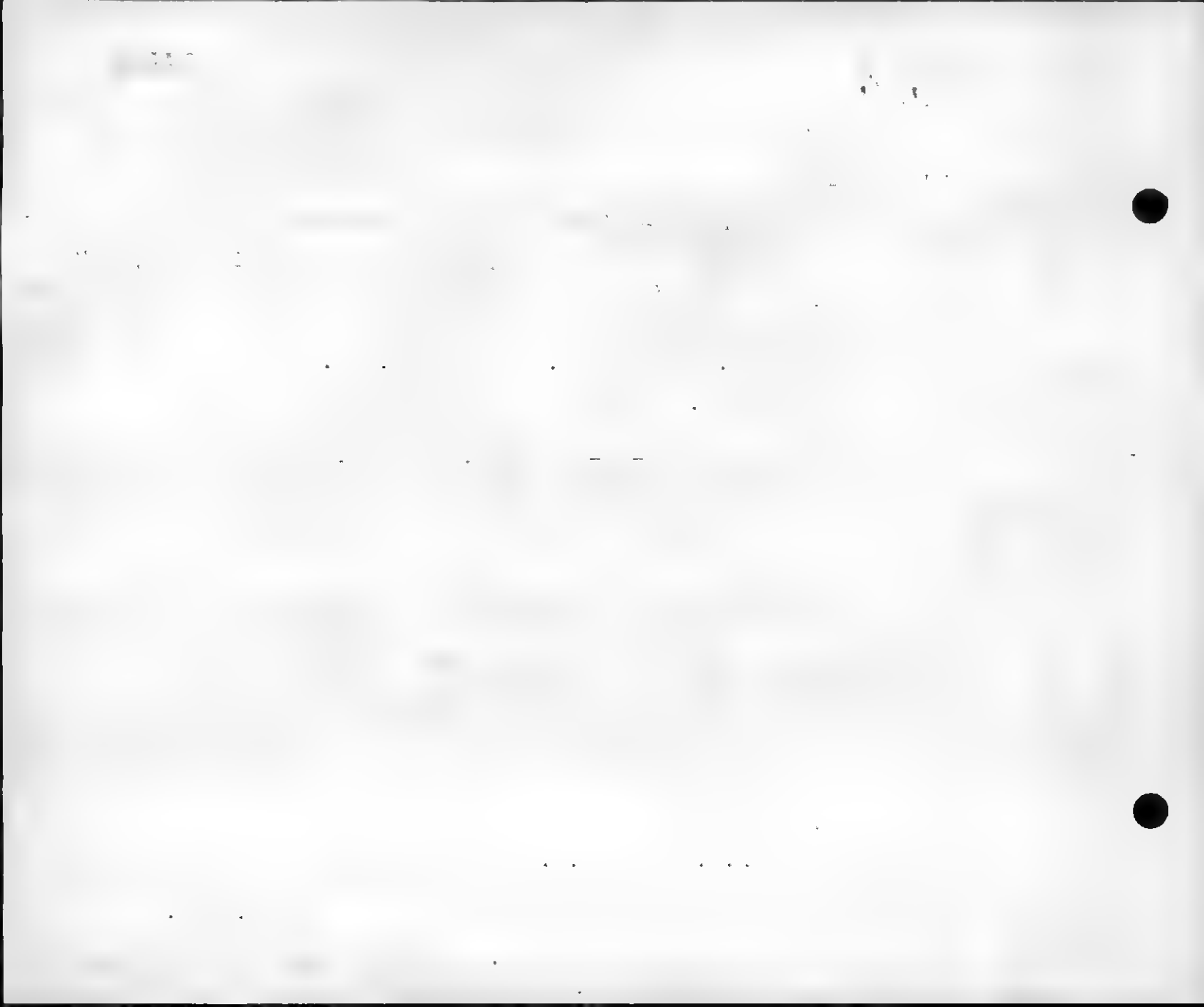
04914

**CERTIFICATE OF DEATH**

04914

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			c. LENGTH OF STAY in 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>105 Charmuth Road-21204</b>				d. STREET ADDRESS <b>105 Charmuth Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>RANDOLPH Dean TAYLOR</b>				4 DATE OF DEATH <b>April 12th, 1967</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/20/1902</b>	9 AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <b>Salesman Balto.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dental Lab.</b>		11 BIRTHPLACE (County & State or foreign country) <b>Phila. Pa.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Charles E. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Velna Dean</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>218-01-6831</b>	17 INFORMANT Address <b>Mrs. Betty J. Taylor 105 Charmuth Rd</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral infarction ± 30 minutes</b> DUE TO (b) <b>Arteriosclerosis, cerebral ± 5 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>No injury</b>					
20c TIME OF INJURY Month, Day, Year hour o m p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>April 21, 1953</b> , to <b>April 12, 1967</b> , that (1) (we) last saw the deceased alive on <b>5 April 1967</b> , and that death occurred at <b>9 A.M.</b> from causes and on the date stated above							
22a SIGNATURE <b>Edward L.J. Holz</b>				22b DATE SIGNED <b>14 April 1967</b>		22c PHYSICIAN'S NAME (Type) <b>Edward L.J. Holz M.D.</b>	
22d ADDRESS <b>7425 Harford Road</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>4/15/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Western</b>		23d LOCATION (City or town) (County) (State) <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Darby Funeral Home 300 Shipley St.</b>				25a REC'D BY REGISTRAR <b>APR 17 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04915

CERTIFICATE OF DEATH

04915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>_____</b>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>1 DAY</b>	
c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d STREET ADDRESS <b>1717 MORELAND AVENUE</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>BERNARD</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>19 67</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APRIL 26 1907</b>
9. AGE (in years last birthday) <b>59</b> yrs.		10. USUAL OCC. PAT. ON (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D. C.</b>
10b KIND OF BUSINESS OR INDUSTRY <b>U. S. GOVERNMENT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HILLARY TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>SARAH AUGUSTA CLARK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>215 44 79 79</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, LEFT</b> <del>ADENOCARCINOMA, PROSTATE</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ADENOCARCINOMA, PROSTATE</b> DUE TO (c) <b>ADENOCARCINOMA, PROSTATE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>  <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>_____</b> m.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (th/s hospital) attended the deceased from <b>APRIL 1</b> , 19 <b>67</b> , to <b>APRIL 1</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 1</b> , 19 <b>67</b> , and that death occurred at <b>500P</b> M, from causes and on the date stated above.			
22a SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED <b>4/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL (CREMATION, REMOVAL) (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>4/6/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24 FUNERAL DIRECTOR <b>ARLINGTON S. PHILLIPS FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>APR 6 1967</b>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>
1727 N. Monroe St. Baltimore, Md.			





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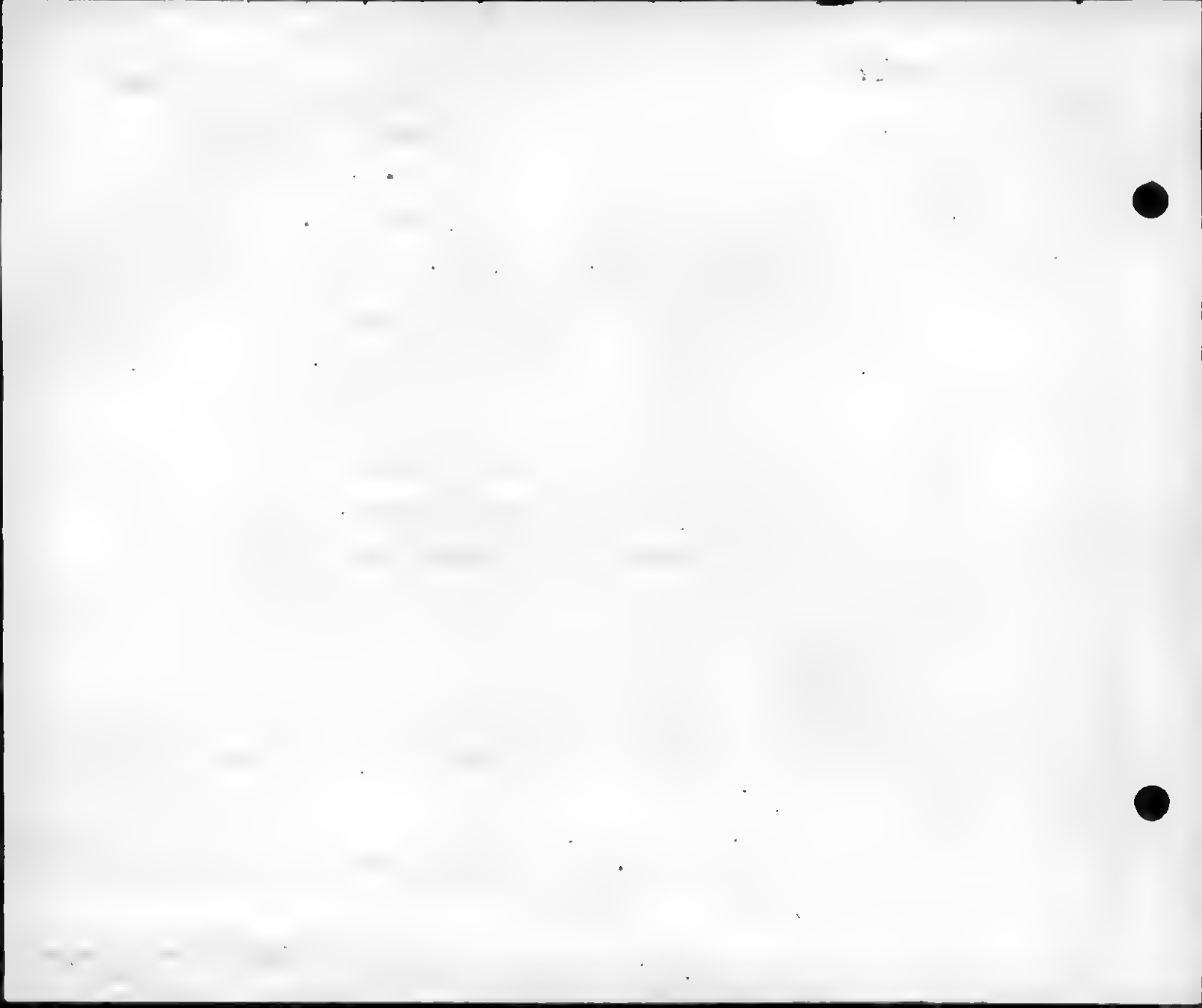
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04916

CERTIFICATE OF DEATH

04916

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a STATE <b>Maryland</b> b COUNTY		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>	
d NAME OF HOSP TAL OR INSTITLT ON (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d STREET ADDRESS <b>9305 Harford Rd.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Phoebe</b> <b>THATCHER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1967</b>					
5 SEX <b>Female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>June 17, 1902</b>	9 AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b KIND OF BUSINESS OR INDUSTRY <b>SPECIALS REST.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PA- U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNK</b>				14. MOTHER'S MAIDEN NAME <b>UNK</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>209-14-5082</b>		17. INFORMANT <b>Hospit Records</b>		Address <b>--</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral infarction and hemorrhage of left hemisphere.</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Occlusion of left carotid artery.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>March 2, 1967</b> , to <b>April 3, 1967</b> , that <b>I</b> (we) last saw the deceased alive on <b>April 3, 1967</b> , and that death occurred at <b>11 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>M.S. Cockburn M.D.</b>				22b. DATE SIGNED <b>April 5, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>April 5, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Crownsville St. Pat's Mch</b>	
24. FUNERAL DIRECTOR <b>Joseph N Zannini 263 S. Conkling St.</b>				25a REC'D BY REGISTRAR <b>APR 7 1967</b>		25b REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



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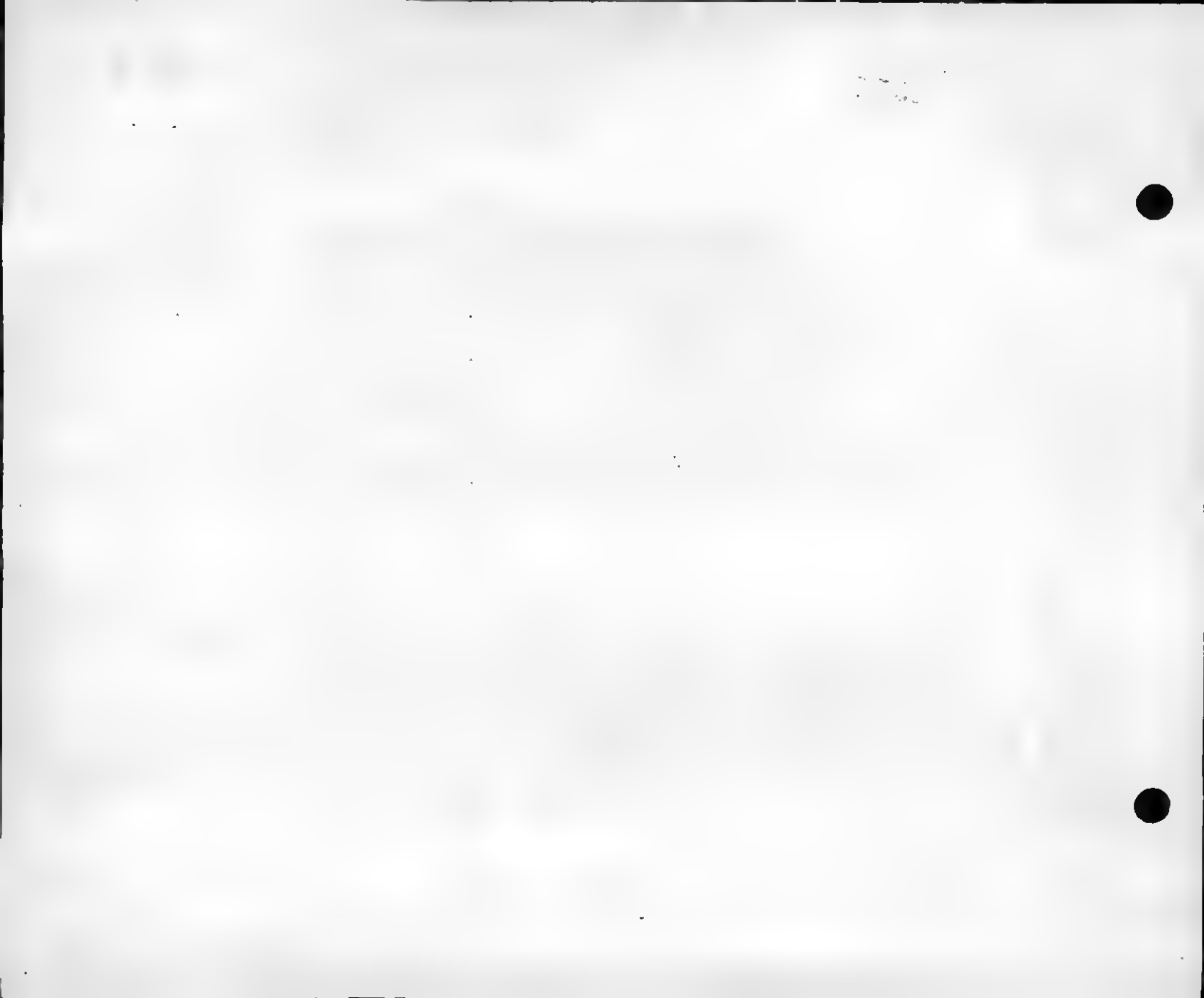
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

04917

04917

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 41201</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>6400 WINDS. MILL RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA ESTELLA THOMAS</u> First Middle Last				4. DATE OF DEATH <u>April 27 1967</u> Month Day Year			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-95</u>	9. AGE (In years last birthday) <u>71</u> Yrs	10. UNDER 1 YEAR Months Days Hours Min <u>7</u> <u>7</u> <u>7</u> <u>7</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS J. THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>CHARLES K. THOMAS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>216-46-2777-1</u>		17. INFORMANT <u>Dr. Raymond J. ...</u> Address <u>6400 WINDS. MILL RD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - C.V.F.</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ASHD; diabetes mellitus</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>67</u> , to <u>4/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/27/67</u> 19 <u>67</u> , and that death occurred at <u>7</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert J. ...</u>				22b. DATE SIGNED <u>4-27-67</u>		22c. PHYSICIAN'S NAME (Type) <u>William J. ...</u>	
22d. ADDRESS <u>6400 WINDS. MILL RD.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			
23b. DATE THEREOF <u>5/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEODON PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>		24. FUNERAL DIRECTOR <u>John T. ...</u>	
25a. REC'D BY REGISTRAR <u>May 1 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

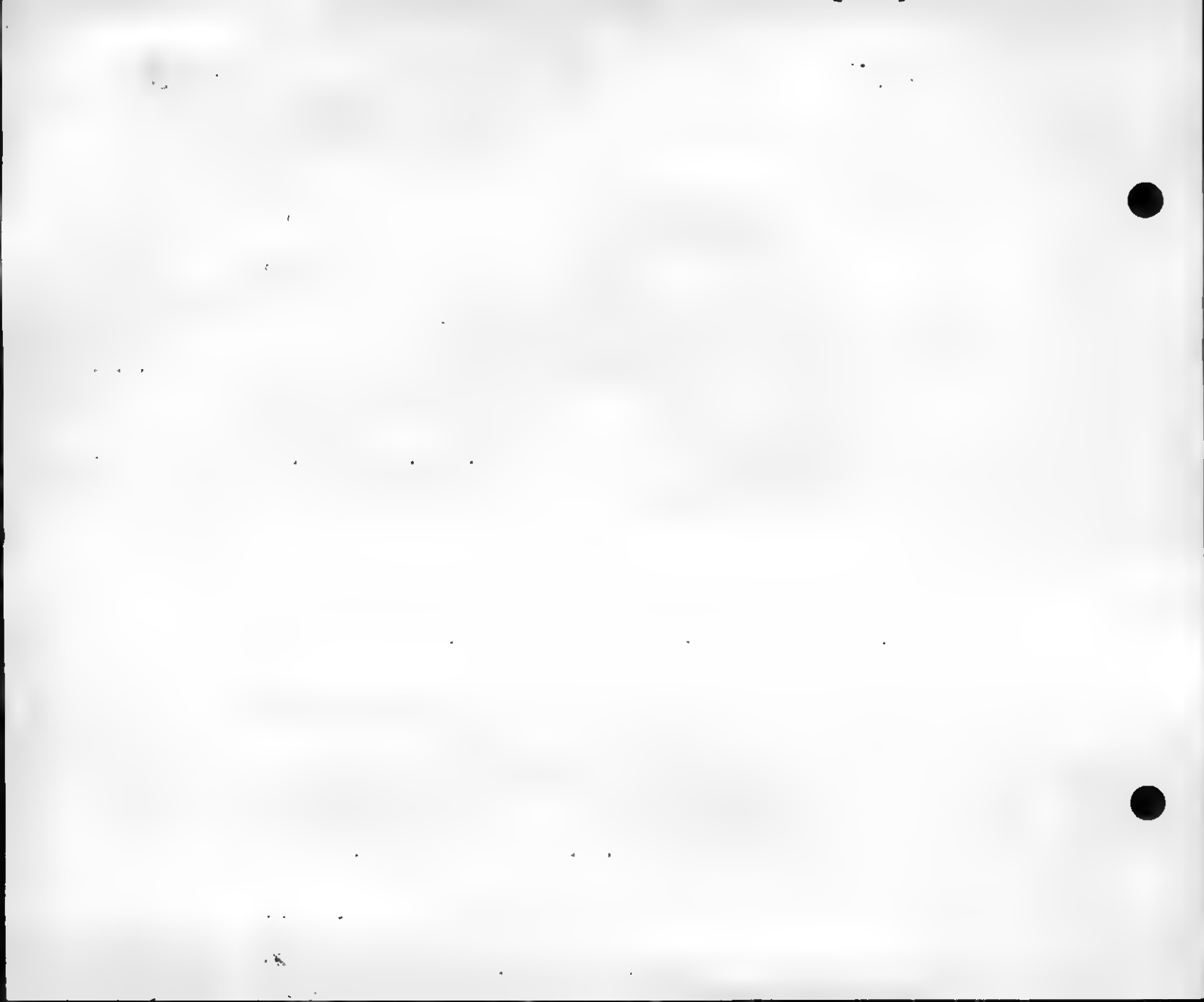
04918

**CERTIFICATE OF DEATH**

04918

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>61 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <i>3.2.4</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>556 BLOOM STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EDWARD</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>24</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 27, 1918</b>		9. AGE (In years last birthday) <b>48</b> yrs	IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b>	IF UNDER 24 HRS Hours <b>---</b> Min. <b>---</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EUGENE THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>HENRIETTA CHASE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW2</b>		16. SOCIAL SECURITY NO <b>218 09 84 07</b>		17. INFORMANT Address <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <i>4/201</i> DUE TO <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>---</b> (c) DUE TO <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME. CHRONIC ALCOHOLISM. POSSIBLE PNEUMONITIS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>---</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>2/23/67</b> to <b>4/24/67</b> , that (b) (we) last saw the deceased alive on <b>4/24/67</b> , and that death occurred at <b>12:50A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Raul F. DeCastro</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAUL F. DeCASTRO, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR <b>PHILLIPS FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>N. MONROE ST. BALTIMORE, MD.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

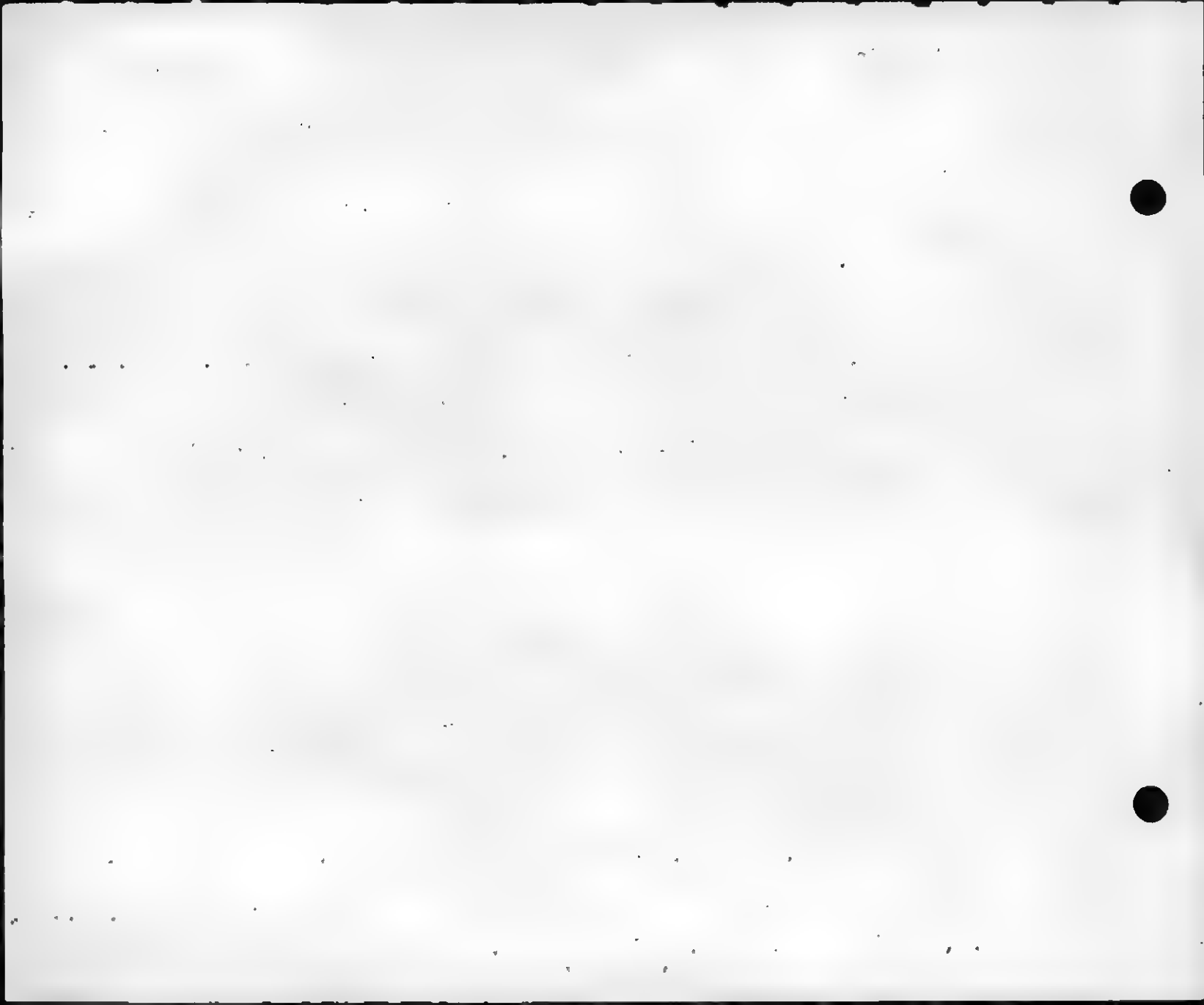
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04913

## CERTIFICATE OF DEATH

04913

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1904 Indian Head Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b> d. STREET ADDRESS <b>1904 Indian Head Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dr. OSCAR B. THOMAS</b>		First Middle Last		4. DATE OF DEATH <b>APRIL 3 1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drugs</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Md.</b>			
13. FATHER'S NAME <b>David Dutrow Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Trundle</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-1442</b>		17. INFORMANT <b>S. James Campbell</b> Address <b>(Same)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 1953</b> , to <b>APR 3 1967</b> , that (I) (we) last saw the deceased alive on <b>APRIL 3 1967</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John M. Scott</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>APR. 3, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. John M. Scott</b>		22d. ADDRESS <b>600 W. Belvedere Ave.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/6/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>			
		23d. LOCATION (City, town or county) (State) <b>Pikesville, Balto. Co., Md.</b>					
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
		4905 York Rd. Balto. 12, Md.					







04920

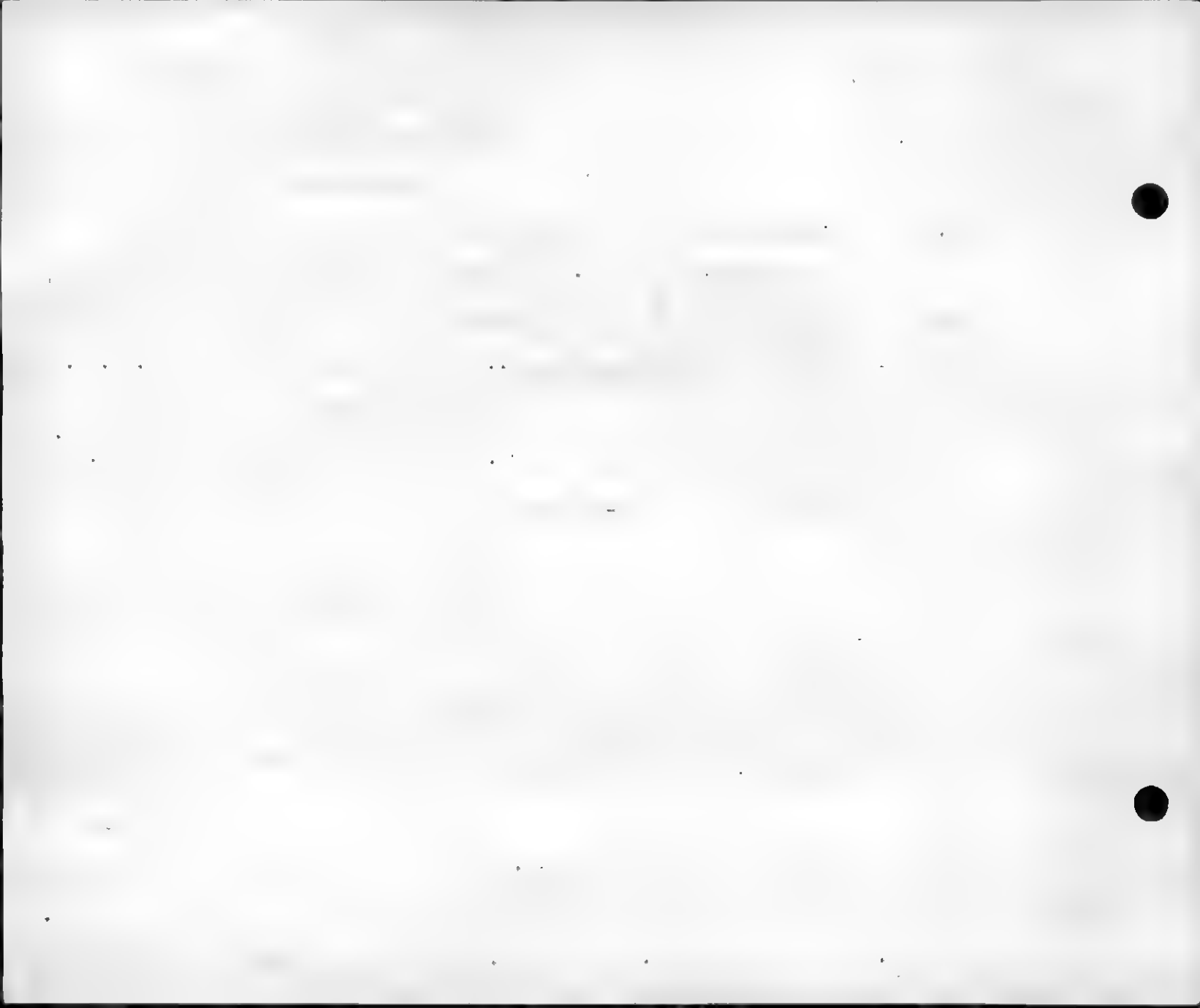
## CERTIFICATE OF DEATH

04920

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3½ weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21222 Dundalk</b>		d. STREET ADDRESS <b>7204 Kimmell Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Homer</b>		First <b>L.</b>		Middle <b>Thompson</b>		Last <b>April 4, 1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1901</b>	
9. AGE (In years last birthday) <b>65 yrs</b>		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elmer Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Emma Hazelton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Army 1925</b>		16. SOCIAL SECURITY NO. <b>216-10-3497</b>		17. INFORMANT (Wife) <b>Mrs. Lucille Thompson 7204 Kimmell Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Terminal carcinomatosis; primary in right lung.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 10, 1967</b> , to <b>April 4, 1967</b> , that <input checked="" type="checkbox"/> (we) saw the deceased alive on <b>April 4, 1967</b> , and that death occurred at <b>2:50 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE  <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>April 5, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>			
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 10 1967</b>		25b. REGISTRAR'S SIGNATURE 			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



STATE OF MARYLAND DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

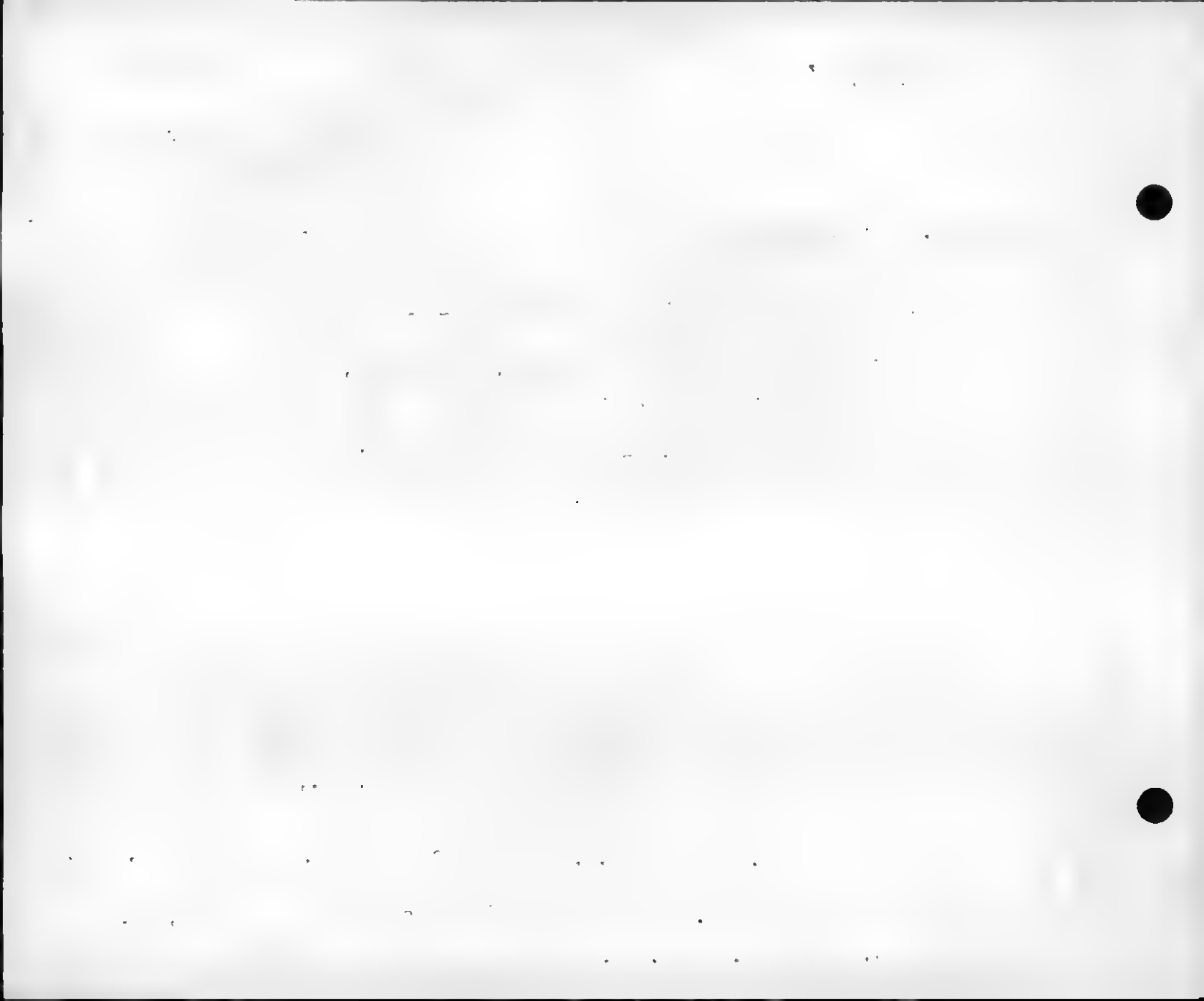
04921

CERTIFICATE OF DEATH

04921

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst tut on. Residence before adm ssion) a STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN lb <b>Baltimore 21212</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		d STREET ADDRESS <b>1671 Northern Parkway</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Anton Fred TOMASSETTI</b>		4 DATE OF DEATH Month Day Year <b>April 9 19 67</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-27-15</b>
9 AGE (In years last birthday) <b>51</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Martin Marietta Co.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Doransino Tomassetti</b>		14. MOTHER'S MAIDEN NAME <b>Frances Ferretti</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <del>if</del> unknown) <b>NO</b>		16 SOCIAL SECURITY NO <b>212-07-7133</b>	
17 INFORMANT <b>Wife - Annie Laura - same as patient</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 443x DUE TO <b>Subarachnoid hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive heart disease</b> DUE TO <b>Hypertensive heart disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>April 2, 19 67</b> , to <b>April 9, 19 67</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>April 9, 19 67</b> , and that death occurred at <b>6:15PM, Md</b> causes and on the date stated above			
22a. SIGNATURE <b>Juana S. Cockburn</b> M.D.		22b. DATE SIGNED <b>4-10-67</b>	
22c PHYSICIAN'S NAME (Type) <b>Juana S. Cockburn, M.D.</b>		22d ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/13/67.</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a REC'D BY REGISTRAR <b>APR 11 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



04922

Item #5 Film #33-1657 pc

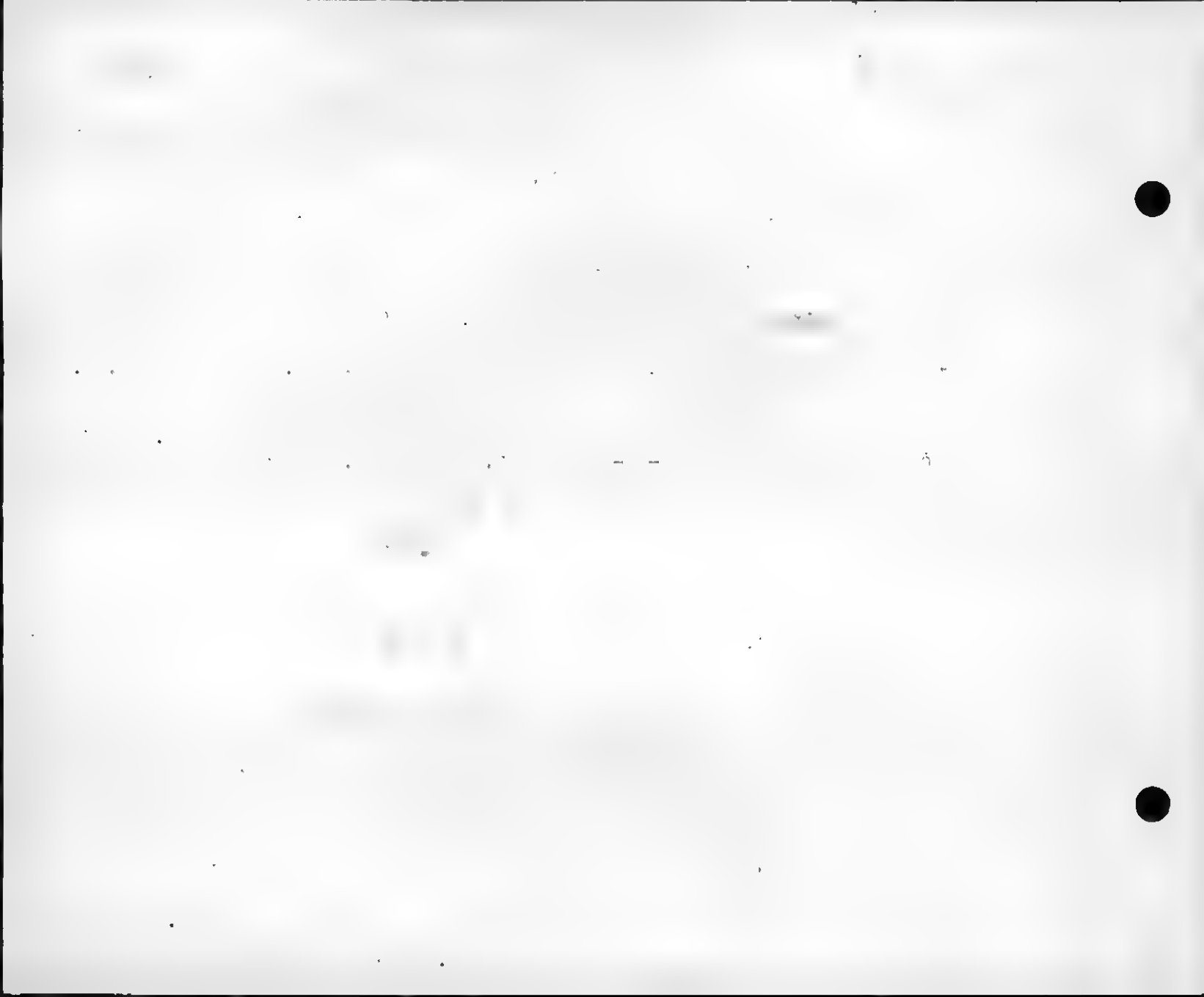
CERTIFICATE OF DEATH

04922

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 21228</b>				c. LENGTH OF STAY IN 1b <b>13 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>				d. STREET ADDRESS <b>2 Park Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Cecil Edward Trinkaus</b>				4. DATE OF DEATH <b>April 6, 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1900</b>	9. AGE (In years last birthday) <b>66 yrs</b>	10. UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Postmaster U. S. Government Post Office</b>				11. BIRTHPLACE (County & State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>C. William Trinkaus</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Teresa Forde</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-32-7961</b>		17. INFORMANT <b>Mrs. Margaret K. Trinkaus 2 Park Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4344</b> DUE TO <b>Coronary failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial damage</b> (b) <b>Myocardial damage</b> (c) <b>Myocardial damage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Upper Respiratory System - Emphysema</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital), attended the deceased from <b>2/1/1</b> , 19 <b>67</b> , to <b>4/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>67</b> , and that death occurred at <b>7:45</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Cecil R. Ratner</b>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CECIL R. RATNER, M.D.</b>				22d. ADDRESS <b>4605 EDMONDSON AVE.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/10/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>				ADDRESS <b>Catonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 12 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

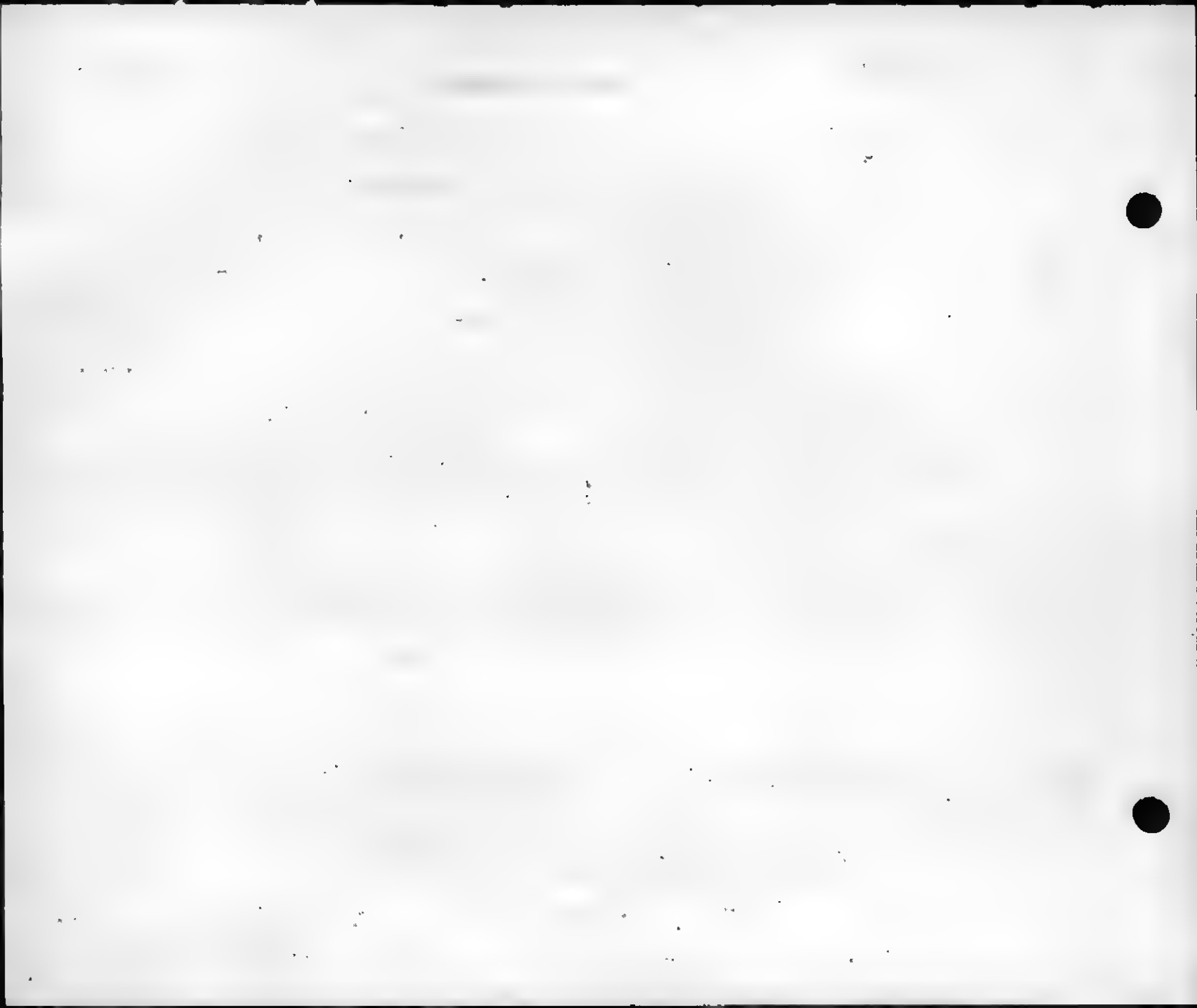
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04923 Item #1d per telephone conv. with physician 04923											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>808 Creek Rd.</b>						d. STREET ADDRESS <b>613 S. Milton Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Martin Tully</b>						4. DATE OF DEATH Month <b>4</b> - Day <b>21</b> Year <b>1967</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-7-07</b>		9. AGE (in years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Tully</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Piechocka</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>WW II 216 09 5015</b>		17. INFORMANT <b>Martha Tully 808 Creek Road #21</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of larynx</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>24 Mar. 1967</b> to <b>21 April 1967</b> , that (I) (we) last saw the deceased alive on <b>24 March 1967</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>M. Rainess M.D.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-21-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>MORRIS RAINESS, M.D.</b>						22d. ADDRESS <b>1105 OLD EASTERN AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>						25a. REC'D BY REGISTRAR <b>2525 Fleet Street</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FINAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04924 CERTIFICATE OF DEATH 04924

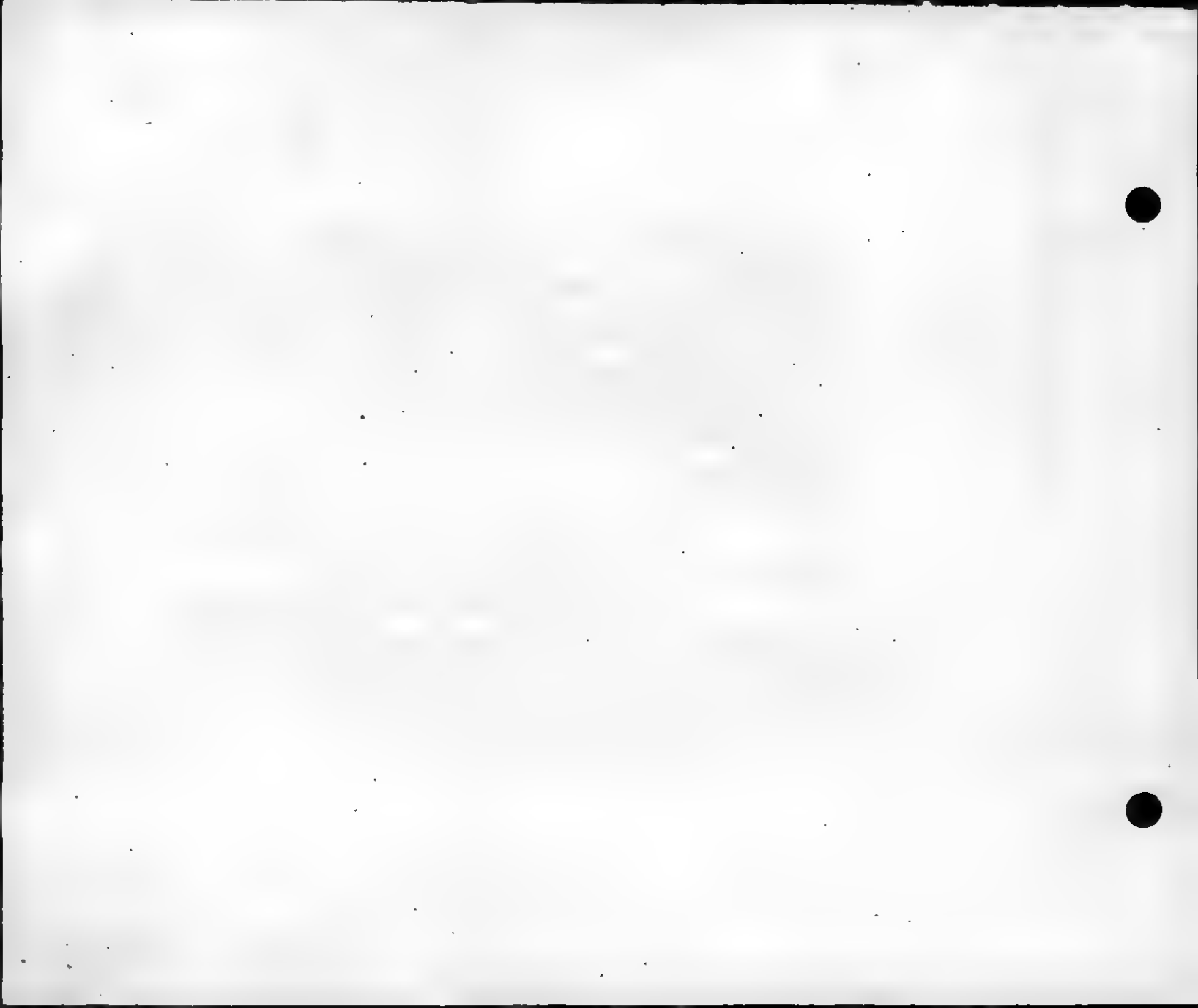
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>Minutes</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6800 Morningson Rd.</b>		d. STREET ADDRESS <b>8524 Kavanagh Rd.</b> 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>D.</b> Last <b>Wagner</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/2/16</b> 9. AGE (in years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Both. Steel Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles A. Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Carrie B. Mossett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>Army WWII</b>		16. SOCIAL SECURITY NO. <b>217-03-4959</b>	
17. INFORMANT (Wife) <b>Mrs. Pearl Wagner</b>		Address <b>Dundalk, Md.</b> <b>8524 Kavanagh Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>A-S-C-V DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-V DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN DEATH AND DEATH <b>2 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>67</b> , to <b>4/16</b> , 19 <b>67</b> that (I) <del>last</del> saw the deceased alive on <b>4/16/67</b> , 19 <b>67</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>M B Davis</b>		22b. DATE SIGNED <b>4/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Melvin B. Davis</b>		M. D. <b>M. D.</b> 22d. ADDRESS <b>6800 Morningson Rd. Dundalk, Md. 21222</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04925  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, give name before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Christine M. Wallnofer</u>		4. DATE OF DEATH <u>April 16 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/1887</u>
9. AGE (in years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>40</u> Hours <u>14</u> Min. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Sigwart</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Wiseman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.	
<u>Yes</u>		<u>1340</u>	
17. INFORMANT <u>Mrs. Alma Hodges Conbright</u>		Address <u>1340 Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Hypostatic Pneumonia</u>			
(b) <u>Cerebral Thrombosis Left Side Temporal</u>			
(c) <u>11/16/67</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio-Vascular Disease &amp; Chronic Thrombosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>66</u> , to <u>4/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>67</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edw. H. Johnson</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD H. JOHNSON</u>		22d. ADDRESS <u>3432 Belair Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City, town or county) (State) <u>4430 Belair Rd. Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Cowan &amp; Son Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>901 Halling St. 23, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>APR 18 1967</u>	



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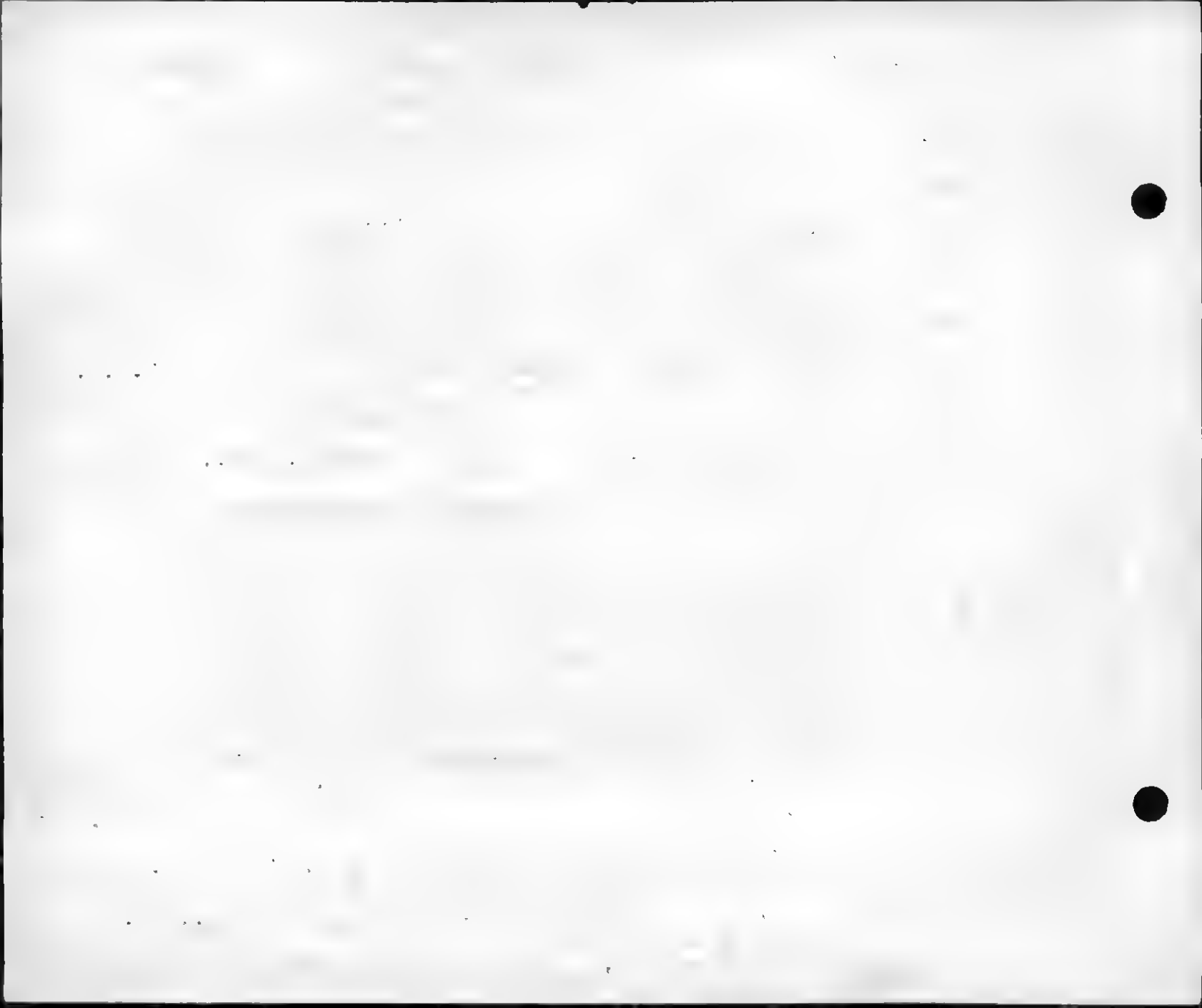
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04926

CERTIFICATE OF DEATH

04926

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21202</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1827 Aisquith St. #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Joseph</b> Last <b>WAMHOFF</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1904</b>	9. AGE (In years last birthday) yrs <b>62</b>	F UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conveyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schaeffer Brewing Co.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Wamhoff</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Snee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-03-9710</b>		17. INFORMANT Address <b>Frances Wamhoff, wife, above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal carcinomatosis, primary in colon.</b> 1500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>January 21, 1967</b> , to <b>April 8, 1967</b> , that <b>10</b> (we) last saw the deceased alive on <b>April 8, 1967</b> , and that death occurred at <b>10 A.M.</b> from causes and on the date stated above							
22a. SIGNATURE 				22b. DATE SIGNED <b>April 8, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b> <b>3331 Brehms Lane, #13</b>				25a. REC'D BY REGISTRAR <b>APR 12 1967</b>		25b. REGISTRAR'S SIGNATURE 	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

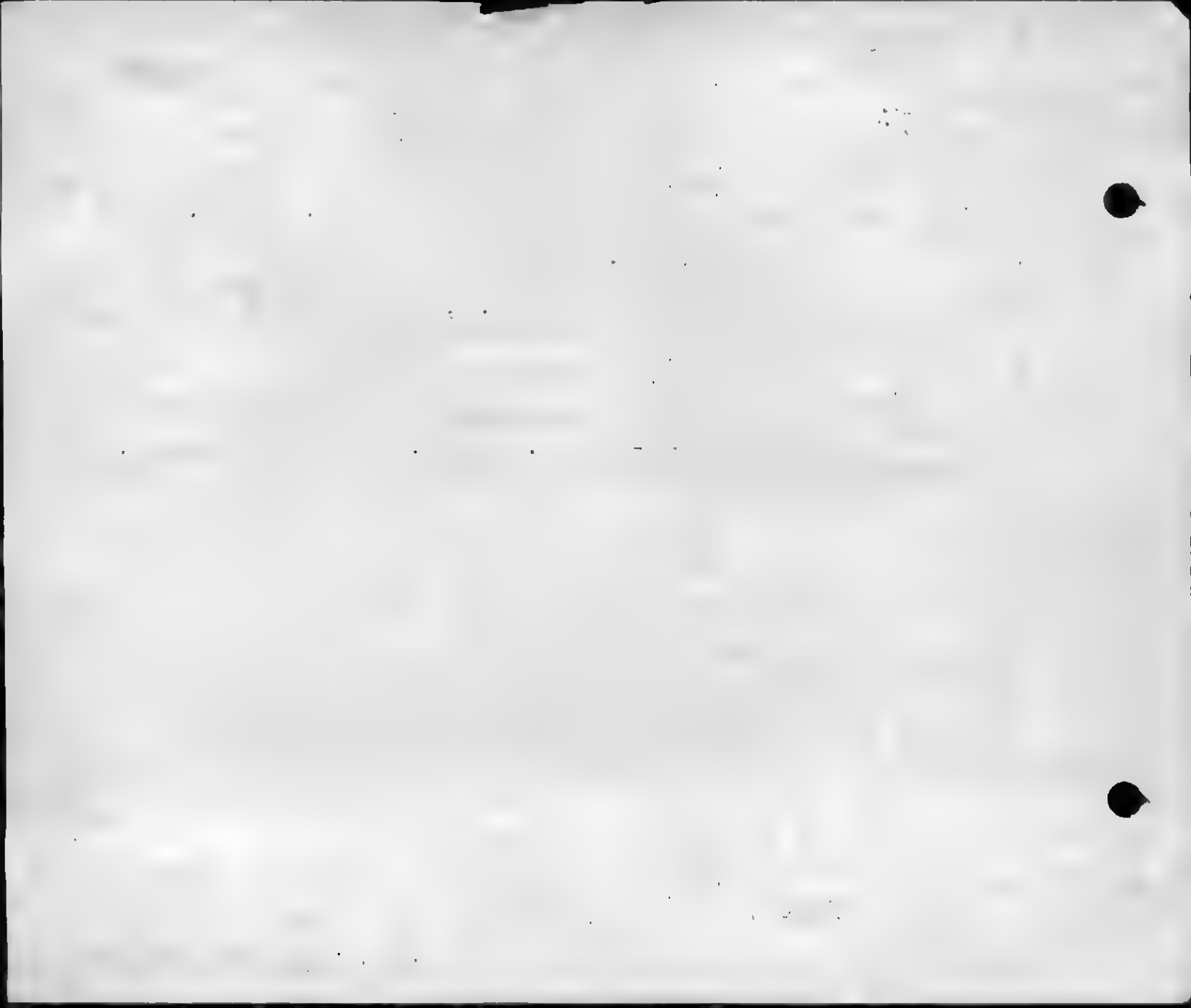
04927

## CERTIFICATE OF DEATH

04928

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>415 North Mt. Holly St.</u> 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Meta C. Warnken</u>		<b>4. DATE</b> Month Day Year <u>April 11, 1967</u>		<b>5. SEX</b> <u>Female</u>									
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 5, 1893</u>									
<b>9. AGE</b> (in years last birthday) <u>74</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Charlady Theater</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Theater</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>Ferdinand</u>									
<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Sophia Berlincke</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-09-3410</u>									
<b>17. INFORMANT</b> <u>Mr. Gordon L. Warnken</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> (b) <u>ARTERIOSCLEROSIS</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>13 DAYS</u> <u>10 YEARS</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/8, 1960</u> <b>to</b> <u>4/11, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>4/11, 1967</u> <b>and that death occurred at</b> <u>2:40 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Paul R. Ziegler</u>		<b>22b. PHYSICIAN'S NAME</b> (Type) <u>PAUL R. ZIEGLER</u>		<b>22c. DATE SIGNED</b> <u>4/13/67</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/14/1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>									
<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. F. Tischer &amp; Son</u>		<b>25. REC'D BY REGISTRAR</b> <u>Charles Judge</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

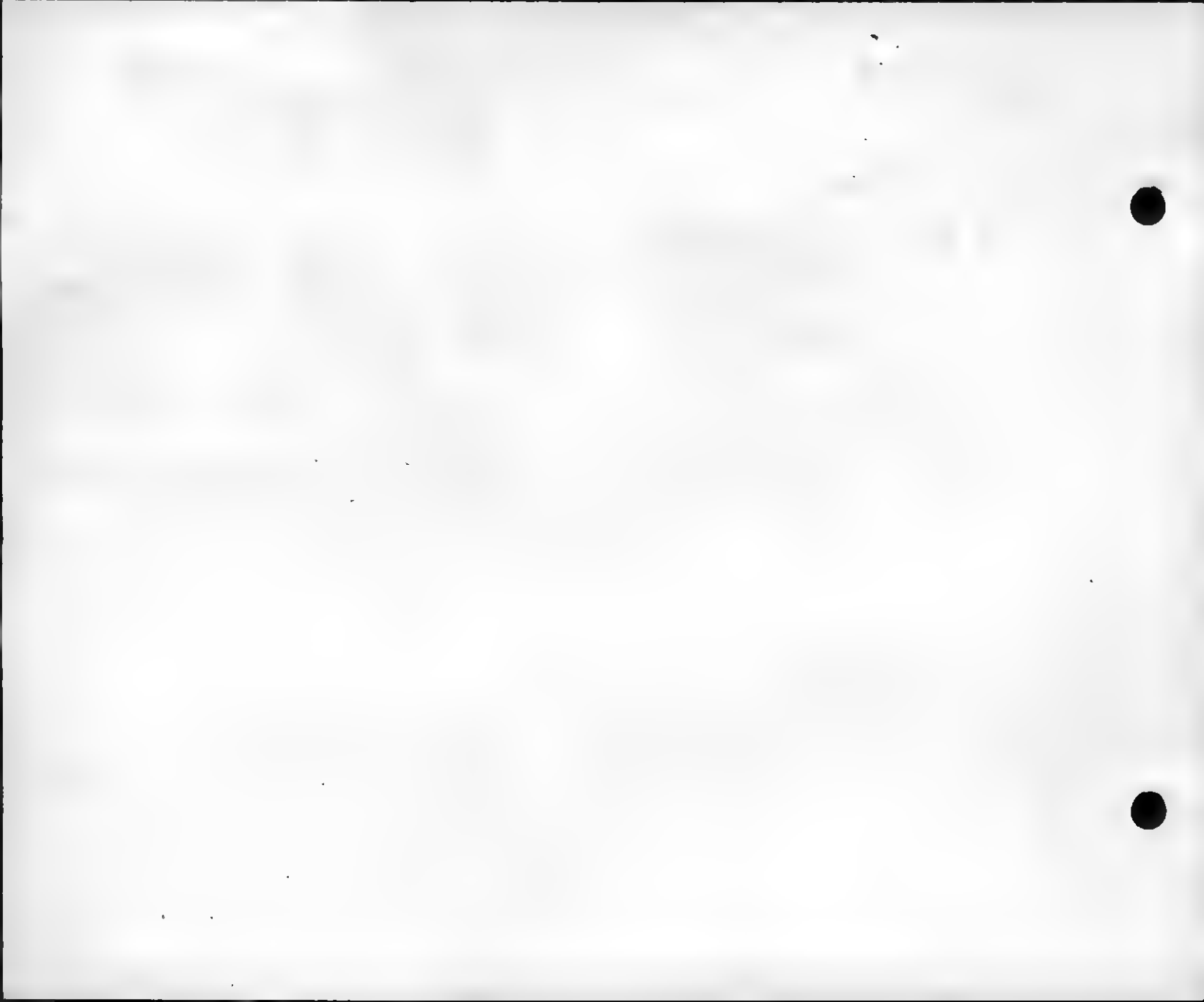
04928

CERTIFICATE OF DEATH

04927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO. CITY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b. <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>				d. STREET ADDRESS <u>358 CORNWALL STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) First <u>GLADYS</u> Middle <u>IRENE</u> Last <u>WARNER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/1891</u>	9. AGE (In years last birthday) <u>75</u> yrs	10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CLEVELAND OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM DAVIDSON</u>				14. MOTHER'S MAIDEN NAME <u>BROWN, Louise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>216-10-5149</u>		17. INFORMANT <u>ADMISSION SHEET</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Resp. Failure</u> <u>1310</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Carcinoma of bladder</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <u>2/17/67</u> to <u>4/4/67</u> , that (if) (we) last saw the deceased alive on <u>4/4/67</u> , and that death occurred at <u>7:10 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Denis Chan</u>				22b. DATE SIGNED <u>4/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/9/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tribner</u>				25a. REC'D BY REGISTRAR DATE <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

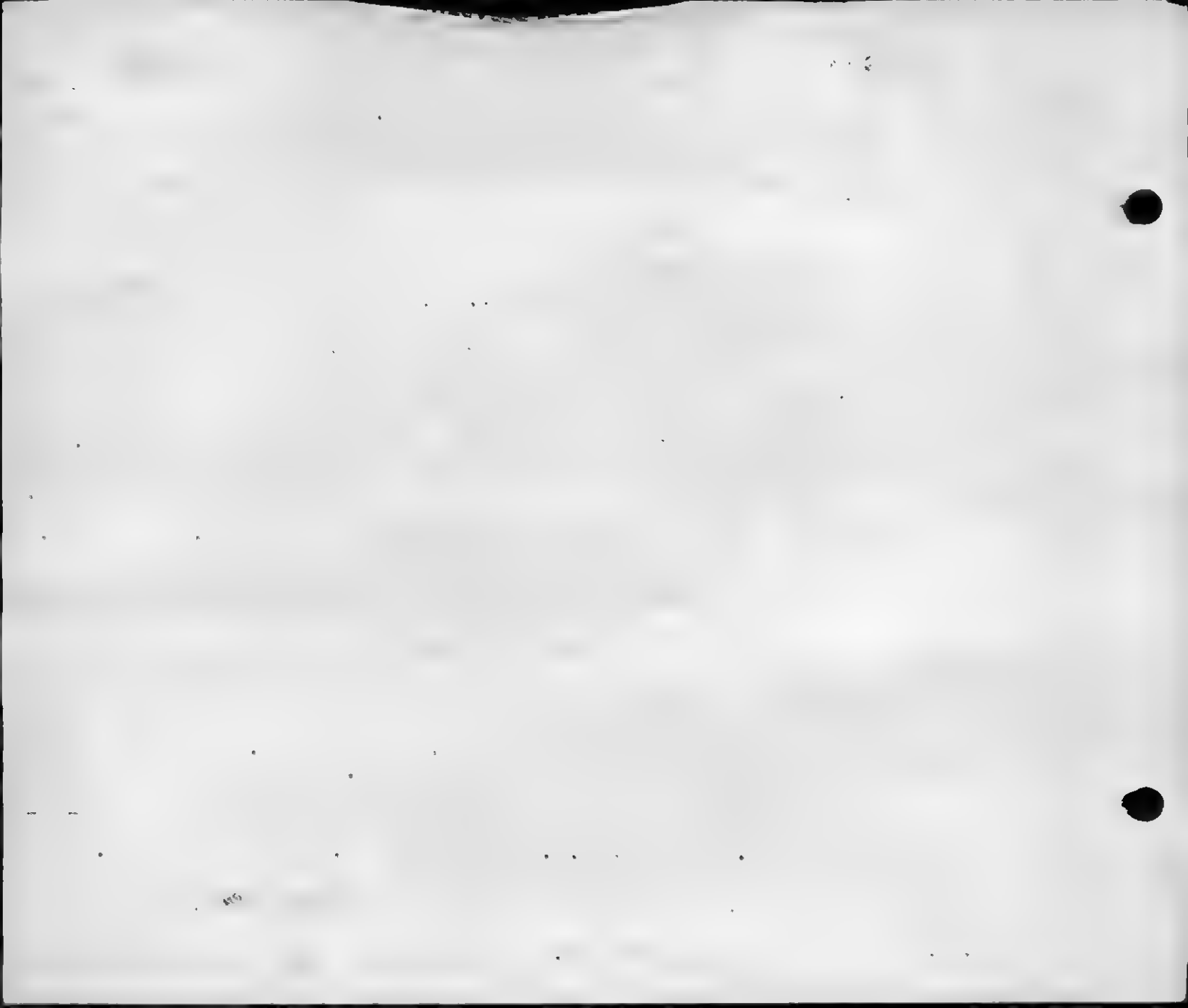
## CERTIFICATE OF DEATH

04929

04929

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>616 Main Street</u>				d. STREET ADDRESS <u>616 Main Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u> First <u>E.</u> Middle <u>Warren</u> Last				<b>4. DATE OF DEATH</b> <u>April 26,</u> 19 <u>67</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 14, 1900</u>	
<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Rock Hall, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Walter Fields</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Dora Deal</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No, or unknown) (If yes give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>216-07-20350</u>			
<b>17. INFORMANT</b> <u>Mr. Walter J. Warren</u>				<b>Address</b> <u>Owings Mills, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic-Hypertensive C.V. Dis.</u> DUE TO (c)							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>15 mins.</u> <u>13 yrs.</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan. 17, 1953</u> <b>to</b> <u>Apr. 26, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 3, 1967</u> <b>and that death occurred at</b> <u>7AM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Martin E. Strobel</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>4-27-67</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Martin E. Strobel, M.D.</u>				<b>22d. ADDRESS</b> <u>48 Main St. Reisterstown, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>April 29, 67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Druid Ridge Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Pikesville, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Eline &amp; Sons</u>				<b>ADDRESS</b> <u>Reisterstown, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>MAY 1 1967</u> <u>Richard J. Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04930

CERTIFICATE OF DEATH

04930

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1732 Arlington Ave. 21227</b>				e STREET ADDRESS <b>1732 Arlington Ave.</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Charles William Watts</b>				4 DATE OF DEATH Month Day Year <b>April 28 19 67</b>			
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 24, 1899</b>	9 AGE (In years lost birthday) yrs <b>67</b>	10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George R. Watts</b>				14. MOTHER'S MAIDEN NAME <b>Jeannette Hettling</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO		17 INFORMANT Address <b>Cordelia Estella J. Watts 1732 Arlington Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the esophagus</b> <b>150X</b> DUE TO <b>Metastasis see to (a)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <b>Cachexia see to (a) &amp; (b)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3</b> <b>6 mos</b> <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 28 1966</b> to <b>APRIL 28 1967</b> that (I) (we) last saw the deceased alive on <b>4-29 1967</b> , and that death occurred at <b>4:00 PM</b> , from causes and on the date stated above.							
22a SIGNATURE <b>Manuel Rodriguez</b>				22b DATE SIGNED <b>4-30-67</b>		22c PHYSICIAN'S NAME (Type) <b>Manuel Rodriguez</b>	
22d ADDRESS <b>435 Chalfonte Drive 21228</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/2/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d LOCAT ON (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>Howard H. Hubbard</b>				25a REC'D BY REGISTRAR <b>MAY 2 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

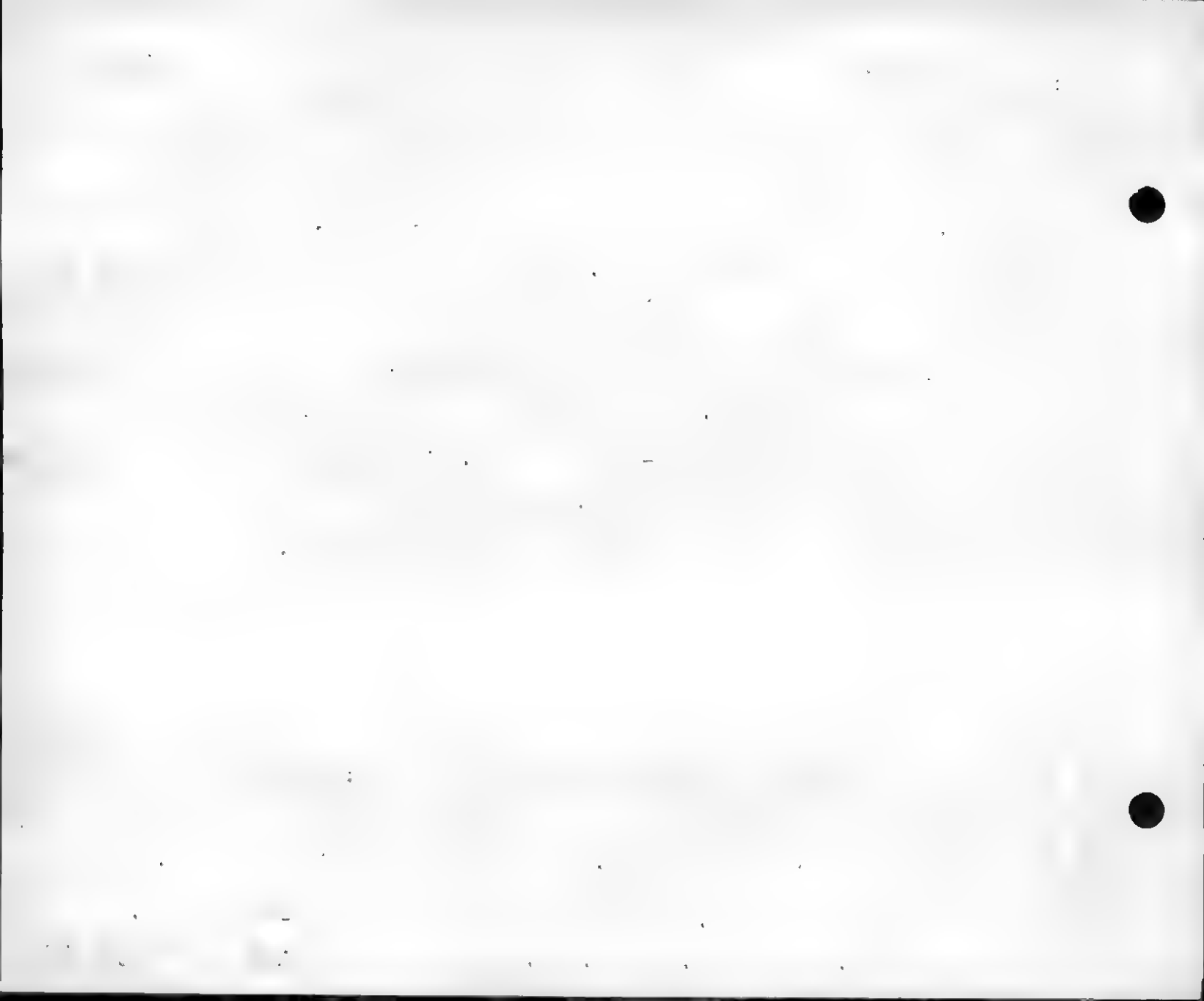
04931

04931

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>21236</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21236</b> d. STREET ADDRESS <b>4235 Soth Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Irving R. WEBSTER</b>			4. DATE OF DEATH Month Day Year <b>April 27, 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1909</b>	9. AGE (In years last birthday) <b>57 yrs</b>	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Burt Machine Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Irving L. Webster</b>			14. MOTHER'S MAIDEN NAME <b>Annie Raver</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>215-07/5547</b>		16. SOCIAL SECURITY NO <b>215-07/5547</b>		17. INFORMANT <b>Mrs. Ann Webster</b> Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> DUE TO (b) <b>Bronchogenic carcinoma, right lung.</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF DEATH Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)		
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>April 26, 1967</b> to <b>April 27, 1967</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>April 27, 1967</b> , and that death occurred at <b>1:15AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>M.S. Cockburn</b>			22b. DATE SIGNED <b>April 27, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>			22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/1/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			25a. REC'D BY REGISTRAR <b>APR 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



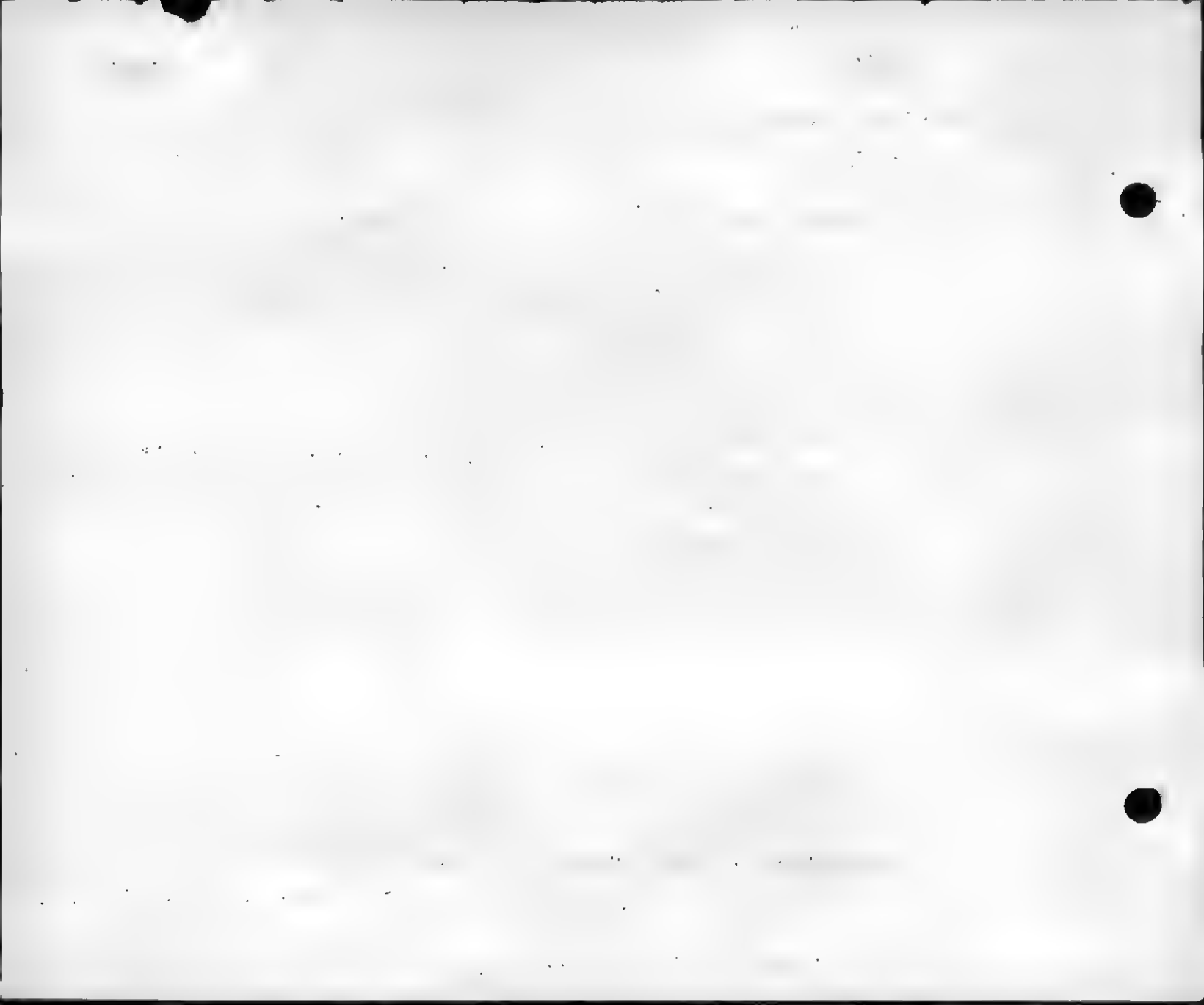


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04932 CERTIFICATE OF DEATH 04932

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VERNON BENJAMIN WEBSTER</b>		4. DATE OF DEATH Month <b>4</b> / Day <b>13</b> / Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/1909</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>2 above</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Webster</b>		14. MOTHER'S MAIDEN NAME <b>Hilda Horseman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Cirrhosis of the liver, and ② Hepatoma.</b> DUE TO (b) <b>③ Chronic alcoholism.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>00-21(c)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① Pulm. TB, moderately advanced, inactive ③ Anemia, due to #2.</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/20/1967</b> to <b>4/13/1967</b> , that (I) (we) last saw the deceased alive on <b>4/13/1967</b> , and that death occurred at <b>4:15 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/18/67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins School of Med.</b>		23d. LOCATION (City, town or county) (State) <b>709 N. Wolfe St. 21205 Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Newell Funeral Home Pikesville</b>		25a. REC'D BY REGISTRAR <b>APR 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04933

CERTIFICATE OF DEATH

04933

TO **SPSIAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. LENGTH OF STAY IN TOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DULANEY TOWSON NURSING HOME</b>				e. STREET ADDRESS <b>3809 BYFIELD ROAD</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Wendell</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>77</b> yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>TOBIAS SADOWSKY</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MR. MARTIN WENDELL, 3809 BYFIELD ROAD #7</b>			
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Canceroma</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>4/21/67</b> , that (I) (we) last saw the deceased alive on <b>4/18/67</b> and that death occurred at <b>11:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Leonard H. Golombek</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEONARD H. GOLOMBEK</b>				22d. ADDRESS <b>7039 LIBERTY ROAD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RIVERSIDE</b>		23d. LOCATION (City or Town) (County) (State) <b>LODI, NEW JERSEY</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

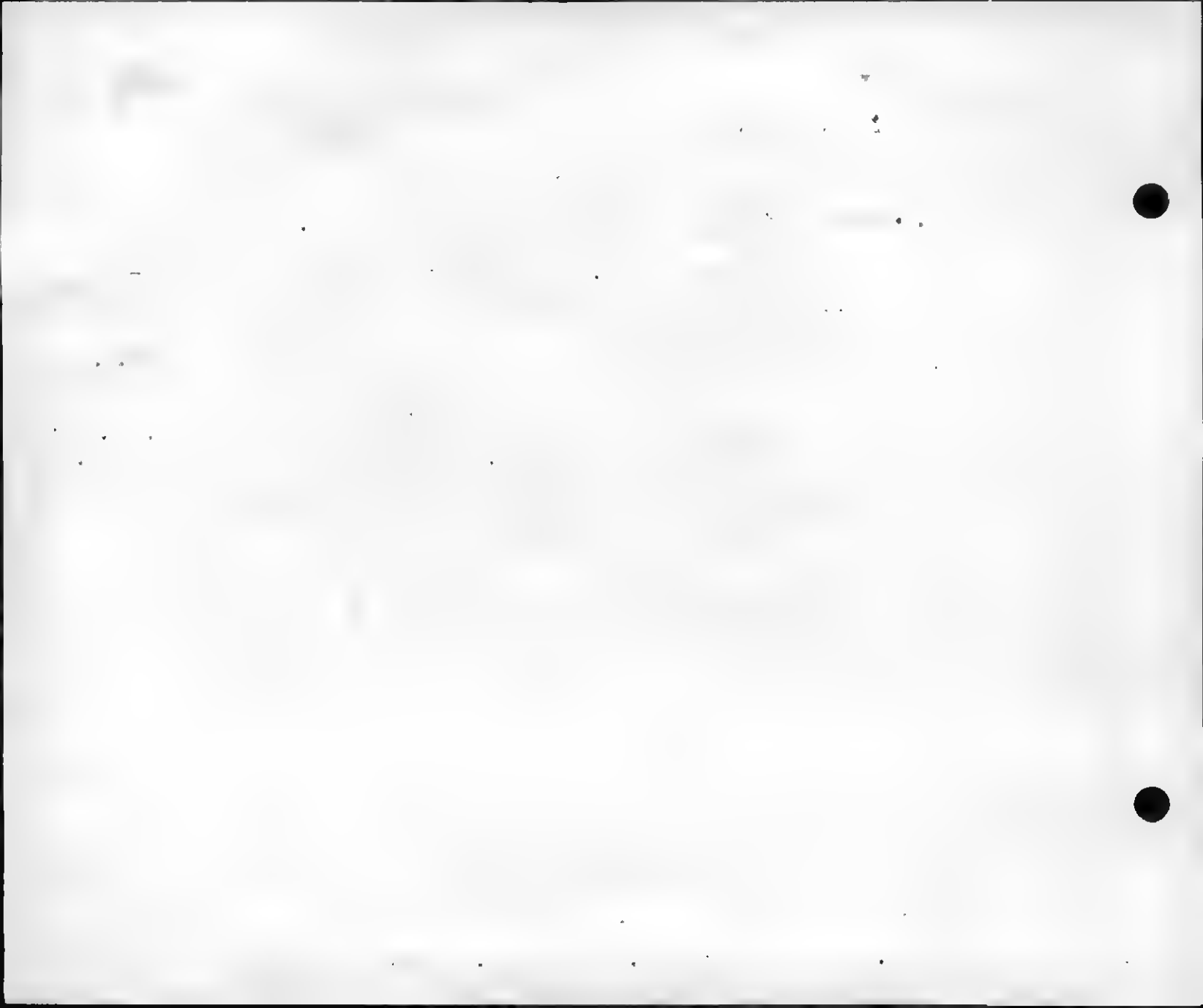
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04934

CERTIFICATE OF DEATH

04934

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b> ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>3 hours</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>1244 Walker Ave. 21212</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gertrude E. Wheeler</b>		4 DATE OF DEATH Month Day Year <b>April 18- 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/88</b>
9 AGE (in years last birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Leopold Rosenzweig</b>		14 MOTHER'S MAIDEN NAME <b>Gertrude Coppe</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>172-18-6071</b>	
17 INFORMANT (Daughter) <b>Mrs. Gertrude Redmond, 1244 Walker Ave.</b>		Address <b>Balto. Md. 21212</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>1-9, 1967</b> , to <b>4-17, 1967</b> , that (2) (we) last saw the deceased alive on <b>4-18, 1967</b> , and that death occurred at <b>5:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W. M. Smith</b> M.D.		22b. DATE SIGNED <b>4/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. M. Smith</b>		22d. ADDRESS <b>16305 ALAMEDA BALTO MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>4/22/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 1967</b>	
25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


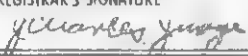
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

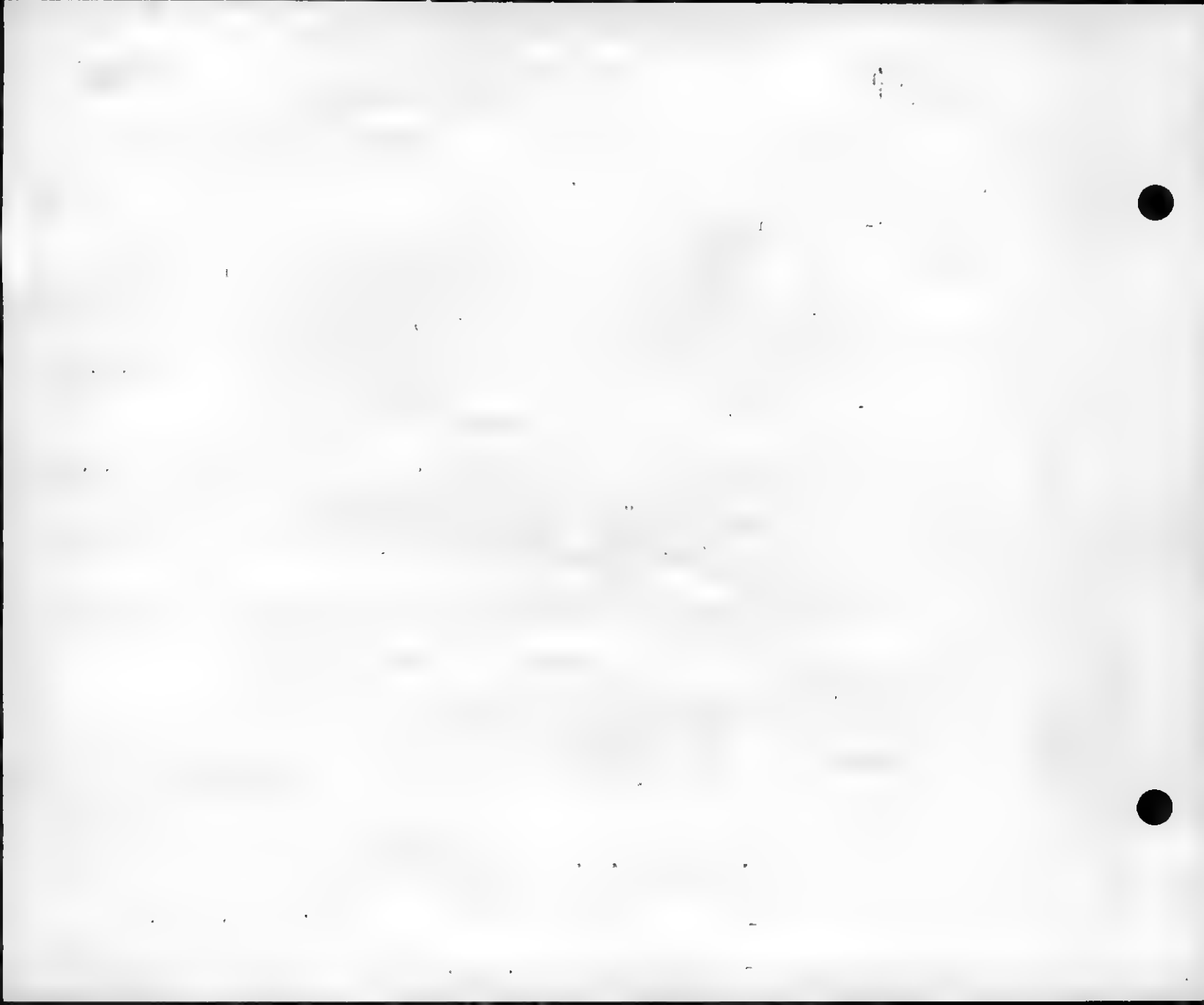
MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04935

CERTIFICATE OF DEATH

04935

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La Nursing Home</b>				d. STREET ADDRESS <b>2310 Poplar Drive</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Baker Whitsitt</b>				4. DATE OF DEATH Month Day Year <b>April 25 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1888</b>		9. AGE (In years last birthday) <b>78</b> YRS	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive and Power</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Superintendent</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Whitsitt</b>				14. MOTHER'S MAIDEN NAME <b>Florie Wallace</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Florie W. Clifford-2436 Pickwick Rd. #7</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable Chronic Heart Failure</b> DUE TO <b>Progressive generalized arteriosclerosis</b> (b) <b>Cerebral Arterial Insufficiency</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>April 24, 19 67</b> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE  M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Emidio A. Bianco, M. D.</b>				22d. ADDRESS <b>3350 Wilkens Avenue, 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>4-27-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>				25a. REC'D BY REGISTRAR <b>DATE APR 26 1967</b>		25b. REGISTRAR'S SIGNATURE 	





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

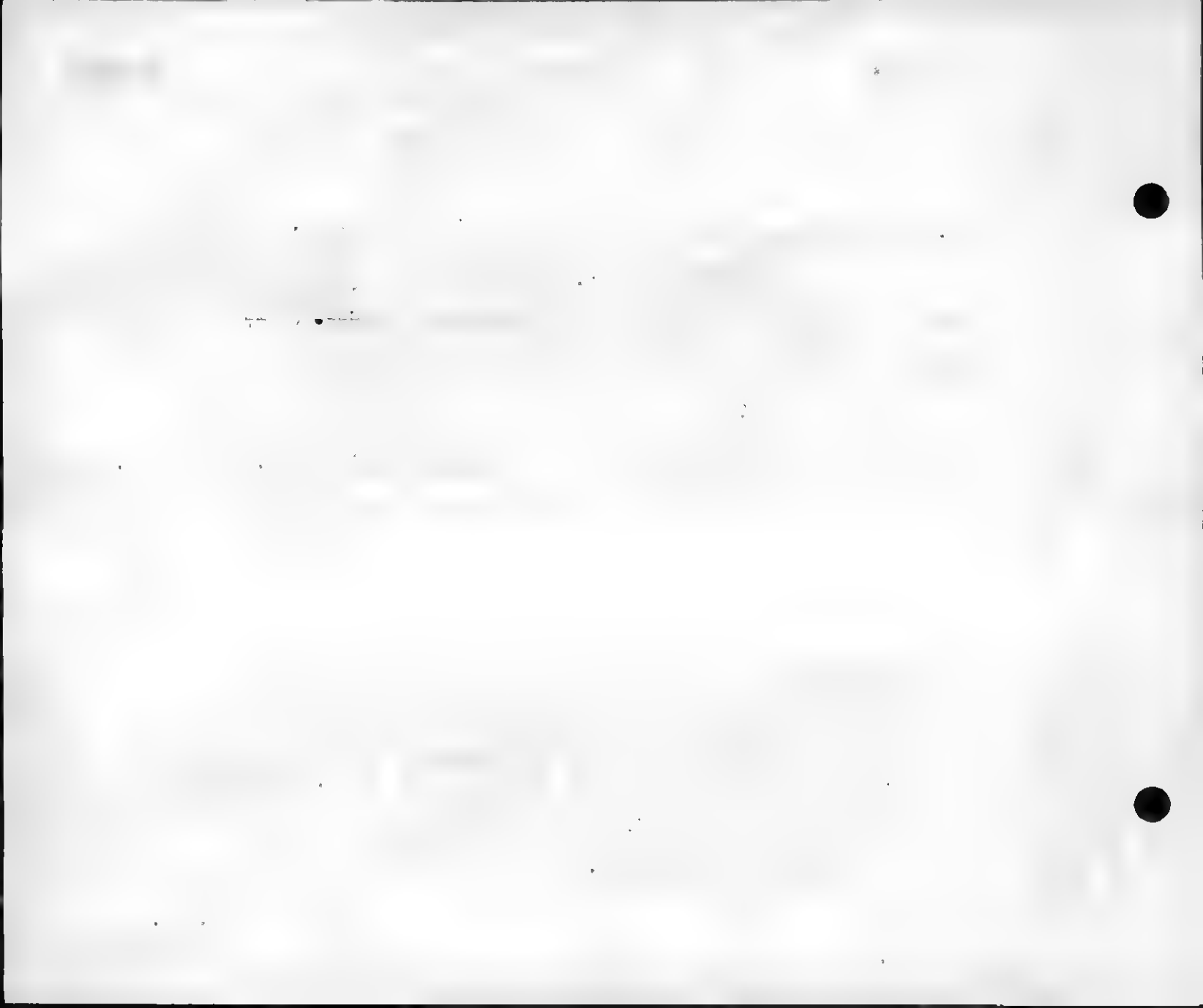
04936

CERTIFICATE OF DEATH

04936

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY _____			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21211</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>510 W. 33rd. St.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>B.</b> Last <b>WICHERT</b>		4 DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1967</b>					
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>September 19, 1898</b> AGE (In years last birthday) <b>68</b> yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min _____
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Julia Kowalski 113 S. Robison St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <b>NO</b> (this hospital) attended the deceased from <b>April 12, 1967</b> , to <b>April 13, 1967</b> , that <b>NO</b> (we) last saw the deceased alive on <b>April 13, 1967</b> , and that death occurred at <b>8 A.M.</b> from causes and on the date stated above.							
22a SIGNATURE <i>Fiorello G. Malit M.D.</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <b>April 13, 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Fiorello G. Malit, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Paul E. Chenoweth 3rd 3617 Chestnut Ave</b>				25a REC'D BY REGISTRAR <b>APR 17 1967</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

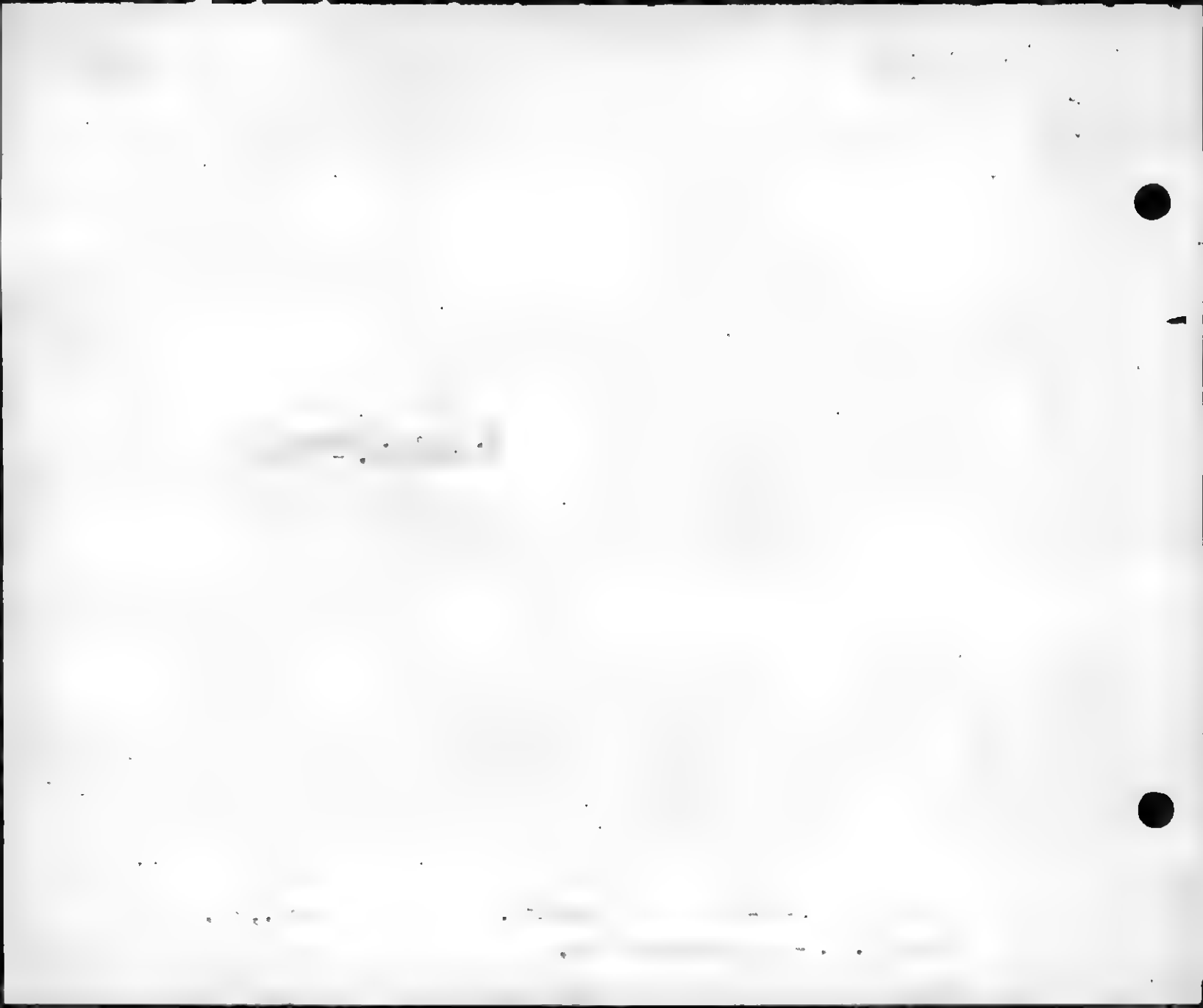
04937

04937

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto. 21229</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>				d. STREET ADDRESS <u>908 Kevin Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise</u>		First Middle Last <u>Widener</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1905</u>	9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Frank Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. John C. Widener</u> <u>908 Kevin Rd. - 21229</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Oedocarcinoma of</u> <u>undetermined Primary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1710</u> DUE TO (c) <u>1710</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>NOVEMBER 19, 1967</u> to <u>April 12, 1967</u> that (I) <del>(we)</del> last saw the deceased alive on <u>4/11/67</u> 1967, and that death occurred at <u>5:25</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Jose Martinez MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE MARTINEZ MD</u>				22d. ADDRESS <u>100 N Broadway 21231</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cath.</u>		23d. LOCATION (City, town or county) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exempted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

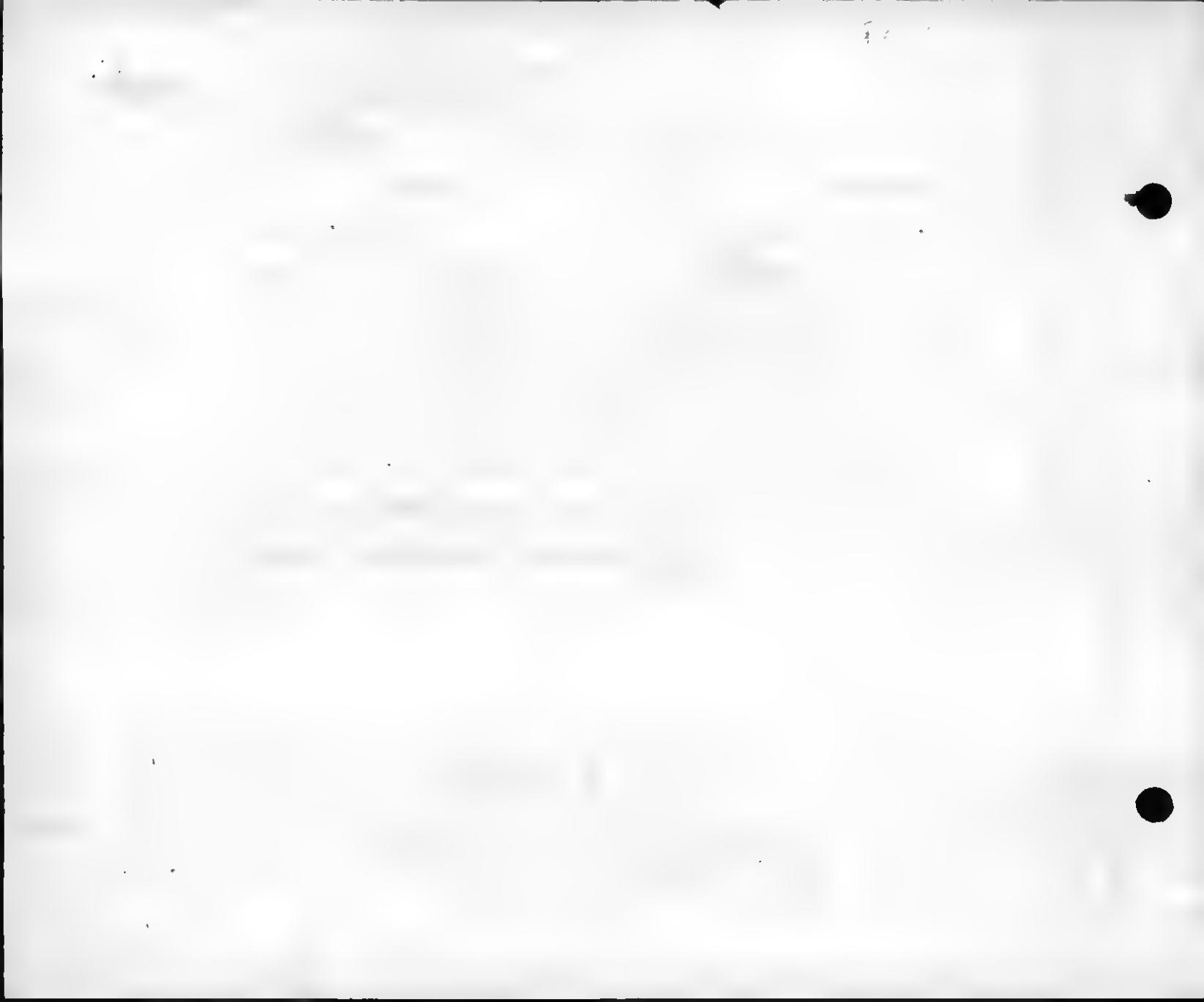
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04938

## CERTIFICATE OF DEATH

04938

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Timonium</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>				d. STREET ADDRESS <b>1911 York Rd. 21093</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Oscar</b> Last <b>WILHELM</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1891</b>	9. AGE (In years last birthday) <b>75</b> yrs	F UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist hepper-retire</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balt. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Edward Wilhelm</b>				14. MOTHER'S MAIDEN NAME <b>Ida Susan Gill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>216-10-6170</b>		17. INFORMANT <b>Family records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive right intra-cerebral hemorrhage</b> <b>443A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 19, 1967</b> to <b>April 20, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 20, 1967</b> , and that death occurred at <b>12:08 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>				22b. DATE SIGNED <b>April 20, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulany Valley Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR <b>John Wynn Sons 610-12 York L. Tow. 21204</b>				25a. REC'D BY REGISTRAR <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

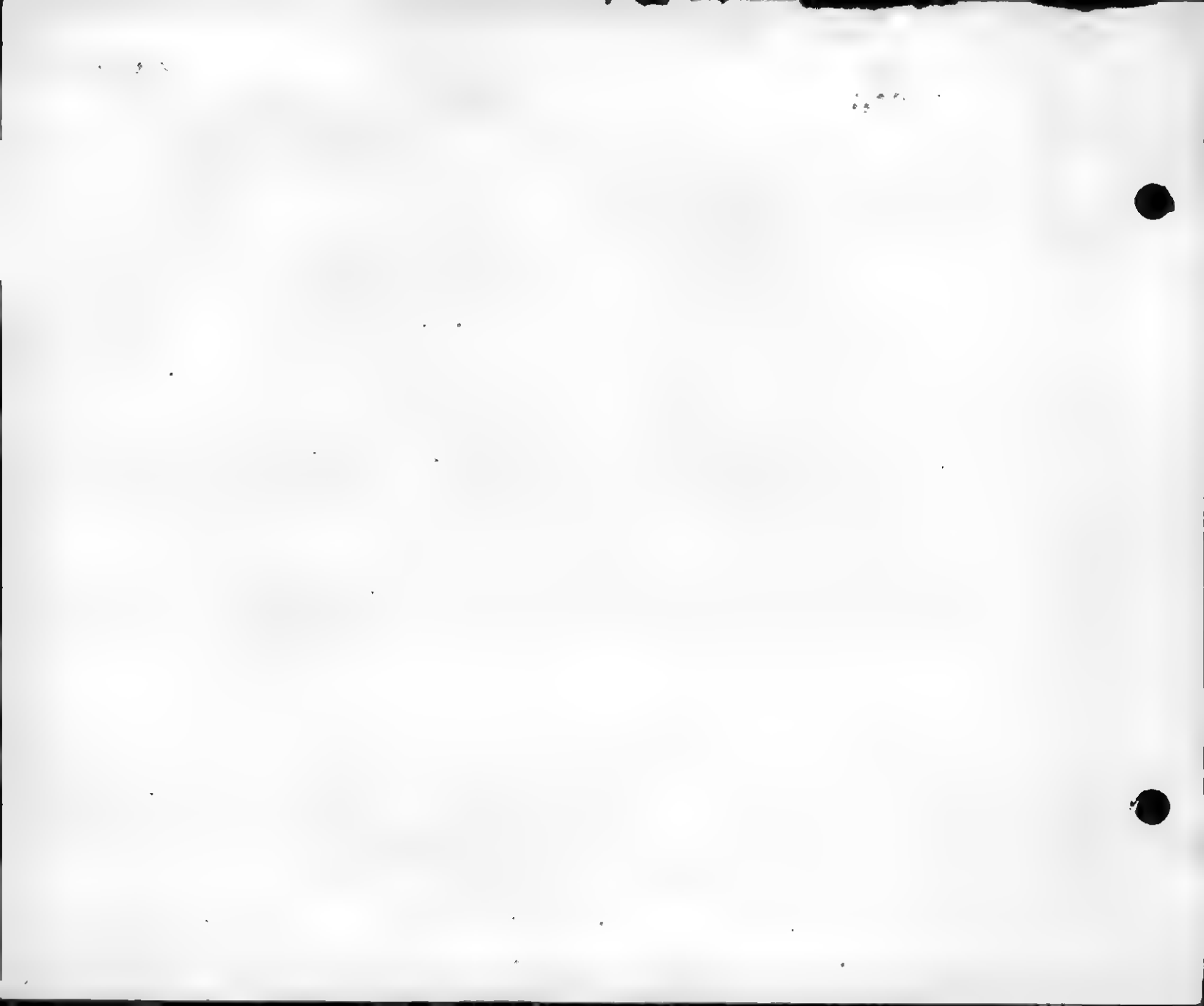
04933

## CERTIFICATE OF DEATH

04939

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5 mthldys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1360 Carroll Street</b>	
<b>3 NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Albert</b> Last <b>Williams</b>		<b>4 DATE OF DEATH</b> Month <b>April</b> Day <b>1</b> Year <b>19 67</b>	
<b>5 SEX</b> <b>male</b>	<b>6 COLOR OR RACE</b> <b>Negro</b>	<b>7 MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>Oct. 4, 1905</b>
<b>9. AGE</b> (In years last birthday) <b>61</b> yrs		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11 BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO</b>	
<b>17. INFORMANT</b> Address <b>Records: Spring Grove State Hospital</b>		<b>18. CAUSE OF DEATH</b> (Enter on any one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Constrictive Heart failure</b> DUE TO (c) <b>Arteriosclerotic Cardiovasc. Disease</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 11</u>, 19 <u>66</u>, to <u>4/1</u>, 19 <u>67</u>, that (I) (we) last saw the deceased alive on <u>4/1</u>, 19 <u>67</u>, and that death occurred at <u>1039</u> AM, from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Narciso W. Carmona M.D.</b>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>NARCISO W. CARMONA</b>		<b>22d. ADDRESS</b> <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/5/67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Auburn</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Charles A. Rice 661 W. Barre St.</b>		<b>25a. REC'D BY REGISTRAR</b> DATE <b>APR 3 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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25M 1/67

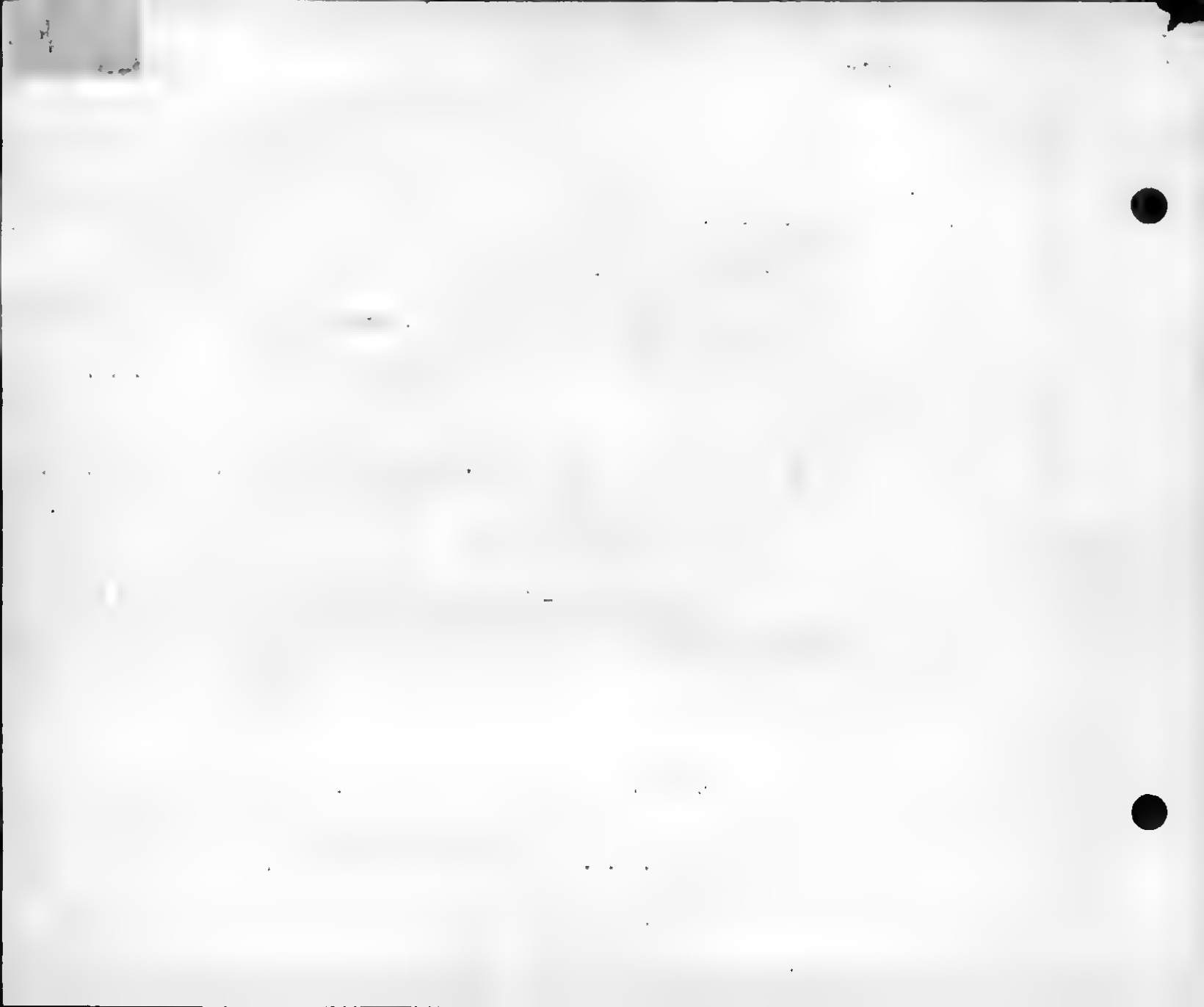
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04940

CERTIFICATE OF DEATH

04940

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>16 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>C</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3907 HILTON ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RUDOLPH</b> Middle <b>-</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 23, 1922</b>	
9. AGE (In years, last birthday) <b>44</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ARTHUR WILSON</b>				14. MOTHER'S MAIDEN NAME <b>RACHAEL WILSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>				16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b> Address	
MEDICAL CERTIFICATE ON 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>CIRRHOSIS OF LIVER</b> DUE TO (c) <b>UPPER GASTRO-INTESTINAL BLEEDING</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS.</b>	
						MONTHS	
						2 DAYS	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PROBABLE PNEUMONIA</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/4/67</b> , 19 <b>67</b> , to <b>4/20/67</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/20/67</b> , 19 <b>67</b> , and that death occurred at <b>11:15 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Pushpendra Senan</b>				22b. DATE SIGNED <b>4/20/67</b>		22c. PHYSICIAN'S NAME (Type) <b>PUSHPENDRA SENAN, M.D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

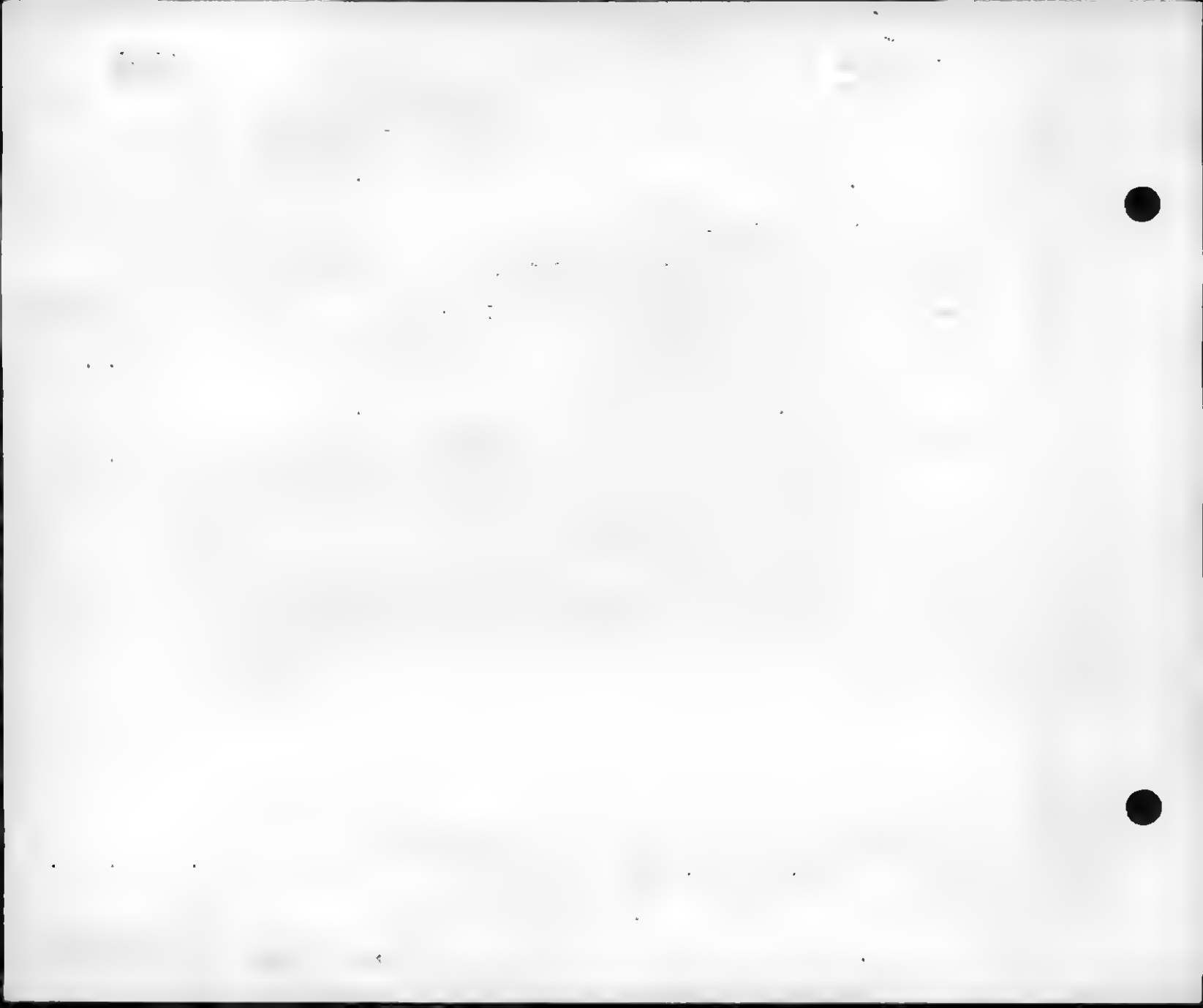
CERTIFICATE OF DEATH

34941

04941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Dennis</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1819 Main Street</b>		e. STREET ADDRESS <b>1819 Main Street</b>	
3 NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>G.</b> Last <b>WRIGHTSON</b>		4 DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>67</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-14-1877</b>
9 AGE (In years last birthday) <b>89</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas E. Gill</b>		14. MOTHER'S MAIDEN NAME <b>Mary K. Ebaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>NONE</b>	
17 INFORMANT <b>Miss Edith Wrightson, 1819 Main St. 21227</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension A.S.C.V.D.</b> ... X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>terminal pneumonia</b> DUE TO (c) <b>Cerebral Thromboses</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May, 1954</b> , to <b>April 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1967</b> , and that death occurred at <b>9:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. John C. Healy</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John C. Healy</b>		22d. ADDRESS <b>1311 Francis Ave. Balto., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-29-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue</b>		25a. REC'D BY REGISTRAR <b>21229</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		25c. DATE <b>MAY 1 1967</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04942

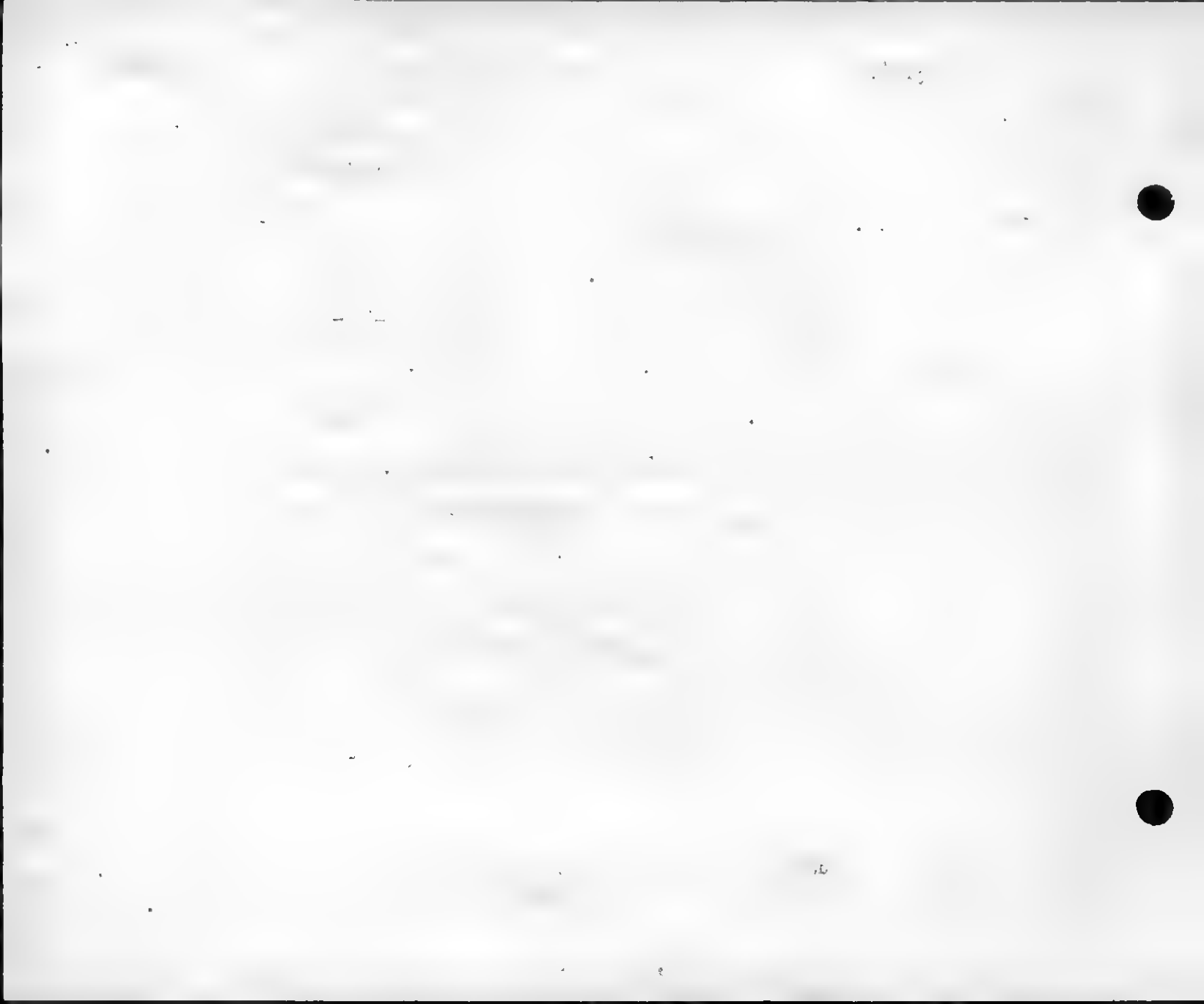
## CERTIFICATE OF DEATH

04942

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>B ALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNBALK</b>		c. LENGTH OF STAY IN 1b <b>21222</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry I. Yeager</b>		4. DATE OF DEATH Month Day Year <b>April 14 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>94 4-16-72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refined Weigher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM C. YEAGER</b>		14. MOTHER'S MAIDEN NAME <b>CLARA RESH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>213-07/3467</b>	
17. INFORMANT <b>MARGARET E. YEAGER</b>		Address AS IN # 2 ABOVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diffuse hemorrhage, large intestine</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease; diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>April 14, 1967</b> , to <b>April 14, 1967</b> , that (2) (we) last saw the deceased alive on <b>April 14, 1967</b> , and that death occurred at <b>9:05 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Juana S. Cockburn</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>April 15, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Juana S. Cockburn, M. D.</b>		22d. ADDRESS <b>7620 York Road, Towson 4, Md.</b>	
23a. BURIAL CREMAT. OR OTHER DISPOSITION <b>BURIAL</b>	23b. DATE THEREOF <b>4/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MD.</b>
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley</b> <b>WALTER BROOKS BRADLEY, MD</b>		25a. REC'D BY REGISTRAR <b>APR 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

04943

04943

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville, Md.</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>				d. STREET ADDRESS <u>Box 13 Bel Air Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johns Hopkins Medical School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First <u>ZANZINEER</u> Middle <u>ZANZINEER</u> Last				4. DATE OF DEATH <u>April</u> Month <u>4</u> Day <u>1967</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1898</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>			
11. BIRTHPLACE (State or foreign country) <u>Providence, Rhode Island</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>John Slingsby Boyes</u>				14. MOTHER'S MAIDEN NAME <u>Edna Boyes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>188-26259</u>		17. INFORMANT <u>Robert B. Bailey</u> Address <u>353 Echo Valley Rd. Newtown Square, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> <u>1557</u> DUE TO <u>CARCINOMA COMMON BILE DUCT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 Mos.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Arthritis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-14</u> , 19 <u>67</u> to <u>4-4</u> , 19 <u>67</u> ; that I last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> ; and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>FORK, MD.</u> DATE SIGNED <u>4/4/67</u> ACTUAL SIGNATURE <u>Clifford F. Hudson</u> PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u> <u>FORK, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>4/5/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins School of Med. 709 N. Wolfe St. Balto.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 6 1967</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD FORM NO. 64



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04944

04944

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Daniels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown 21133</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3221 Offutt Road</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WILLIAM</u> Last <u>ZINKHAM</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1942</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months <u>24</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Wall Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward L. Zinkhan</u>		14. MOTHER'S MAIDEN NAME <u>Frances L. Schmidt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-4380</u>	
17. INFORMANT <u>Mr. James V. Oldaker-3221 Offutt Rd.</u>		Address <u>Randallstown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TAMPORADE DUE TO</u> <u>823.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LACERATION OF HEART</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>PASSENGER AUTO RAN INTO TREE</u>	
20c. TIME OF INJURY Month, Day, Year <u>214</u> <u>4/11</u> <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>STREET</u>		20f. (City or town) (County) (State) <u>DANIELS BALTO CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		22. DATE SIGNED <u>4-1-67</u>	
EXAMINER'S NAME (Type) <u>RUSSELL S. FISHER, M.D.</u>		Address (Street, city, town, or county) <u>Trumps Mill Rd, Balt., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Faith</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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